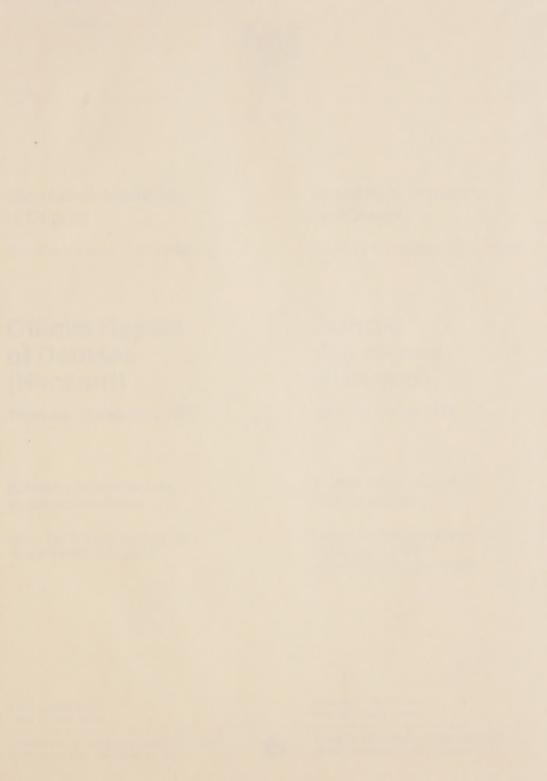


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Thursday 18 February 1993

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Standing committee on social development

Long Term Care Statute Law Amendment Act. 1993

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Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Président : Charles Beer Greffier: Douglas Arnott

Chair: Charles Beer Clerk: Douglas Arnott

Editor of Debates: Don Cameron



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 18 February 1993

The committee met at 0907 in Centennial Hall, London

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. I think while people thaw out, take their coats off and get a hot cup of coffee, we'll call the meeting to order. This is the morning session of the standing committee on social development in London's Centennial Hall, and we're here to review Bill 101, An Act to amend certain Acts concerning Long Term Care.

CHATEAU GARDENS NURSING HOMES

The Chair: I'd like to call our first deputation for this morning, the representatives from Chateau Gardens. If they would be good enough to come forward, take a seat, make yourselves comfortable; have a glass of water. We welcome you to the committee. If you would be good enough to introduce yourselves both for the committee members as well as for Hansard and then please go ahead.

Mr Ron Gingrich: Good morning everyone. I'm Ron Gingrich. I'm the executive director of Chateau Gardens Nursing Homes. With me is Darlene Fitzgerald. She's the administrator and the director of care of Chateau Gardens Queens Nursing Home in London, a not-for-profit nursing home, and Donna Letts, the administrator and director of care of Chateau Gardens Parkhill, a for-profit nursing home.

Chateau Gardens finds itself in a unique position in that we operate under the definitions of both for-profit and not-for-profit. In reality today, all our homes are non-profit due to lack of appropriate funding caused by delays in the passage of this bill.

We believe the seniors of Ontario deserve more consistency in standards and funding of care delivery. We support and applaud the efforts of this committee to facilitate the implementation of long-term care reform and we encourage you to move forward with this bill.

I realize time is limited, so I will only give you a brief synopsis of our written submission and then we'll be pleased to address any questions you may have.

While there are many sections in this proposed legislation that are positive, our concerns pertain to the wording of portions of Bill 101 and its omissions. There are many unanswered questions raised by the way the bill is written. We are concerned about a wide range of problems that could be created by the approach taken. While we see an

intention to be more equitable, some amendments continue to discriminate against residents of nursing homes. The government must be held accountable to maintain equitable and consistent services in all long-term care facilities throughout Ontario.

We are apprehensive about the movement away from extended care to a contractual agreement model. It disturbs us that there will no longer be a universal accessible approach to health care in these facilities as the extended care program will no longer be an insured service under OHIP in Ontario

There is no specific language outlining the content of what these service agreements will entail. In fact, to date, not even a draft of what the service agreement may state is available for anyone's review. Equally unsettling is that, again, there is no accountability placed on the government to provide the funds to meet this service agreement.

The development of a case-mix index, which scores one facility's care level relative to another, by no means guarantees that funding will be sufficient to ensure that the assessed needs of the residents are met.

This bill holds facilities accountable for providing for all resident needs without ensuring that funding will be provided to make this possible. The legislation clearly states that the care outlined in a resident care plan must be provided.

The problem is, there is no flexibility should the resources not be available to provide the services outlined in the care plan. In fact, this legislation may seriously discourage accurate and detailed plans of care due to lack of resources, and to make matters worse, because there is not enough money in the system to meet all of the residents' assessed needs as identified in their care plans, facilities will automatically be in breach of their contract.

We recommend that the legislation not require facilities to provide all services as defined in the care plan unless government assumes responsibility for funding these services.

There are no details of how the placement coordinator will function. We suggest their duties be outlined in the legislation and that this position be given the responsibility to determine eligibility for placement; to identify a substitute decision-maker for the applicant; to determine the applicant's ability to pay the copayment; to identify a responsible party in the event there is default of the applicant's payment; to take into consideration the applicant's choice with respect to ethnic, linguistic, geographic and religious preferences, or discharge planning and coordination involved when a resident needs to be moved to another location, and to provide service seven days a week, 24 hours a day.

We would also suggest that existing resources be used for their function and that no new level of bureaucracy be created for this purpose. Eligibility determination should be a combination of physical, medical and social requirements. Facilities must have the right to define their missions and the type of services they are able to deliver. Both applicants and facilities must be able to refuse a placement based on the client's preference and the home's ability to meet the resident care needs. Both applicants and facilities must have a timely and efficient appeals mechanism with respect to placement.

The immunity clause that protects placement coordinators and inspectors for acts done in good faith must be expanded to include facility staff as well.

With regard to the sanctions, we must wonder if the bill is not creating a potential nightmare for the residents and their families. In many cases, sanctions such as freezing admissions or withholding payments will in fact jeopardize the provision of care to residents still in the facility. Sanctions should only be implemented as a final resort, and facilities must have the right to appeal the sanctions implemented.

We are extremely disappointed to see the reintroduction of the word "inspector." Past experience has shown that the inspector model created an adversarial climate that was not in the best interests of quality care. It failed dismally. All long-term care facilities, regardless of their profit designation, must be reviewed using the same standards and criteria. We strongly support the continuation of the current compliance management program which stresses consultation rather than confrontation.

We question why the powers of the inspectors need to be increased. The recently passed Bill 74, the Advocacy Act, negates this need, as the advocates will help to communicate and assist residents with unresolved issues and problems. That is the purpose of Bill 74; let it do its job.

While we support the concept of quality assurance programs, the term itself is outdated. In the past two to three years, for instance, my company has grown from a basic quality assurance program to a more refined total quality management program. I would suggest a more generic term such as "quality management" be used.

In addition, I do not support inspectors being given powers that allow them to review and possibly use our TQM information for their own purposes. I respectfully submit that allowance of this will cause a facility to develop an ambiguous approach to self-evaluation and the whole philosophy of TQM will become meaningless. Very seldom does government legislation encourage growth. Allow us to monitor our quality of service without bureaucratic intervention.

Consistent with the above concern is our aversion to the inspectors having any rights to personnel records, peer reviews or performance reviews. This can only be seen as a total invasion of staff privacy and serve to meet no rational goal. I also wonder what confidentiality issues would be breached.

This bill has given far too much power to the government and inspectors without the corresponding accountability. Consumers and facilities, however, have been given very little power, protection or choice. This bill leaves too many issues to be defined by regulations.

In summary, I would like to stress that this bill should provide reasonable and equitable guidelines for all long-term care. Don't reintroduce policing by inspectors. Keep the consultative approach using the compliance management program. There are many talented and dedicated people in both the for-profit and not-for-profit sectors. Bring them together under one act that addresses everyone by the same standards, criteria and funding schedule.

The Chair: Thank you very much for your presentation. I think you are the first witness who has the combination of both non-profit and for-profit, so we thank you very much for coming before the committee. We'll begin our questioning with Mr Wessenger.

Mr Paul Wessenger (Simcoe Centre): Thank you for your presentation. The first question I'd like to ask: You haven't seen the draft program manual? It does contain a draft agreement and there will be a second draft coming out soon.

Mr Gingrich: No, I have not seen it.

Mr Wessenger: The other thing I'd like to ask is, you're familiar with the existing system of inspection under the Nursing Homes Act, which basically tries to work with a compliance model. Does that work well at the moment?

Mr Gingrich: We find it works very well. I think my administrators could probably answer that better since they deal directly with the compliance managers. But we find it works very well.

Mr Wessenger: It certainly is the intention to continue the present model with respect to the nursing homes. I'd like to also assure you that the matter of the language of the quality assurance plan is under review. We have to see if we can have more appropriate language in that regard.

The Chair: Just before moving to Ms Caplan, I believe the committee had copies of that, so it's something I'm sure could be forwarded to you.

0920

Mrs Elinor Caplan (Oriole): The concerns you've raised have been repeated before at this committee and there have been some suggestions about the type of amendment that might at the same time provide accountability and assure quality in a more positive way than the big stick approach of the inspector, or what I refer to as the enforcement model, which just didn't work in the past and isn't going to work in the future. It really is outdated. I'm pleased to hear that you think that the total quality management and continuous improvement approach, combined with compliance management, is working well. I know there were some concerns about it when it first came in.

The question I have for you is around accreditation and whether you believe that, in order to build in appropriate accountability without that policeman coming in, whether a feature in this bill that required the establishment of a quality management program and the requirement or the mandate of meeting of an accreditation perhaps under the association of long-term facilities, which is establishing accreditation programs both for management as well as outcome review, whether you in your facilities would have

a comfort with that as an alternative. Because the public must be protected. You want to do this in a positive way, I believe, but we have to find a way that is going to be forward-looking and will result in improved patient care and quality.

Mr Gingrich: We are accredited as, yes, most facilities are.

Mrs Caplan: Not all facilities are right now. That's why I've been asking the question. I did not know if you were or not.

Mr Gingrich: Yes, we are fully accredited, all of our facilities. We feel that there is some overlap between the compliance management program and the accreditation. My administrators would, I think, assure me that they feel it's an overlap.

Mrs Caplan: So you would be comfortable if an accreditation process were in place and you could satisfy the accreditors that you had a quality management program within your facility as part of the accreditation? You could even perhaps lessen some of the bureaucracy that's existing in the compliance management program today?

Mrs Darlene Fitzgerald: I was up for reaccreditation, because we've been accredited since 1980 at our home. They reviewed my total quality management or continuous management improvement then, whatever they're going to end up calling this when they're finished with it. They reviewed it and found it very positive and thought we were doing very well with it.

Mrs Caplan: Because I know that's a field that is changing rapidly and that instils prides in an institution when it achieves that and the big stick is not needed if you have that kind of culture and value within your facility. It's ensuring that the accountability is there. The other proposal was to mandate a residents' council in all long-term care facilities, and that's not a requirement in this legislation. Would you have any problem with that kind of amendment?

Mrs Fitzgerald: We have residents' councils in our facilities and have had for any number of years. Nearly all of our facilities have them.

Mrs Caplan: And you found that a good thing in your facility?

Mrs Fitzgerald: I find it a good thing from that point of view because they audit all our departments in one of the monthly meetings they have. That provides a quality assurance for us.

Mrs Caplan: I just point out that this is not a requirement in the legislation now, but several have suggested that if you were going to move to make the bill a little more progressive and forward-looking, that's the sort of thing you could mandate for all institutions and then look at perhaps accreditation and quality management programs.

The last question—

The Chair: The last question.

Mrs Caplan: Thank you. It was suggested last evening that there be a statement of principles, a preamble or perhaps a statement as it related to the role of the placement coordination service, almost a statement of principles

that would give comfort to some of the concerns around consumer choice and flexibility. What was suggested was a statement of principles—and I'd like to read it into the record—that encompassed "dignity and integrity of the individual," "reasonable and competent access to information about alternatives in care," "informed consumer choice," "equitable access to services and facilities for clients and their families (within appropriate limits)," "sensitivity to cultural, religious, ethnic and language issues in so far as this is possible," "competent, experienced and academically well prepared staff" and "no vested interest in service outcome." Those would be the principles for ensuring appropriate admission criteria.

My question is, do you feel that it would be important to have that statement of principle in the legislation, and do you believe that facilities should be able to have a right to refuse, subject to appeal, if they don't feel they're able to provide appropriate care for the client?

Mr Gingrich: Yes, I believe I have addressed that. I do feel we need that option. Each facility is slightly different, and in some cases we may not be able to provide the care required by the residents.

Mrs Caplan: Would you have any difficulty with the notion of "appropriate care" being defined in regulation?

The Chair: Excuse me, Ms Caplan. I've got to move on; I'm sorry. Mrs Cunningham.

Mrs Dianne Cunningham (London North): Thank you. Good to see you. Again, I want you know that we have an establishment here that's been very helpful, I think, to all governments, Mr Beer. We certainly visit Chateau Gardens; I think all the members do from time to time. We're very happy to get firsthand visitations and good advice on what should happen. Thanks for coming today.

My questions are going to be rather simplistic because I haven't followed the intricacies of the bill; my two colleagues have been doing that on behalf of our party. But I am interested in the whole issue of quality assurance. Do you think there's enough of a mechanism in our facilities now for quality assurance? Do you think the quality is assured?

Mrs Fitzgerald: Yes, I do, with the mechanism we use where we are evaluating the quality assurance and then all of the risk management things that go for quality assurance for us. We also do utilization review as well. There are any number of areas that you improve upon, particularly when you're dealing with any occupational health and safety issue. They fall under risk, and the quality assurance program, or TQM, helps us to find a solution for those particular problems. Then they're worked out logically and methodically. It's been a very helpful system.

Mrs Cunningham: With regard to consultation, I know that you're talking about the reports we've done with regard to the consultative approach. In your view, is that happening now. I know you said you approve of it, but why would anybody be raising a different issue here, from the government's point of view? Is there something happening out there where we've had to move towards inspectors and another way of doing things? Is there something that we

don't know about? Why would the government be putting this kind of thing in legislation?

Ms Donna Letts: I believe that it's kind of backward thinking. We have a concern. We really don't know why the inspector model has been raised again. The compliance program has been working well.

Mrs Cunningham: It's something that we tried to avoid in our school systems in the late 1950s, and I'm

happy that you pointed it out.

My other question has to do with the contractual model at the very beginning here, where you're talking about how "there will no longer be a universal, accessible approach to health care in these facilities." I suppose this has been an issue at least since I've been elected, for the last five years. Are you saying that if we pass this legislation and I'm trying to keep the funding separate, because I don't think you need legislation around funding: I don't think anybody has to come to the government and say. "We need this legislation because we know we need another funding model, because outside of this legislation we knew we needed another funding model." I don't think we need it. It has been, for the last five years, at least as long as I've been doing this work, another ploy in not having to deal with the real issue. Separate from that, why will we now have a two-tiered system, if this bill is passed?

Mr Gingrich: Under the service agreement approach, obviously each facility will have its own agreement with government on its operation. I guess our fear is that there's nothing to guarantee that it'll be renewed. It has to be renewed each year, as I understand, and our apprehension is that it could be broken, for whatever number of reasons. It is of course very important that we have an agreement to operate our facility.

0930

Mrs Cunningham: So you're saying that if in the contract the government demands that you provide certain services, and given the money that you are able to get, either from the client or from the government of both, you can't do it if you don't fit into what it feels you should be doing. Even with less money, they wouldn't perhaps sign the contract.

Mr Gingrich: That's possible.

Mrs Cunningham: So is this the old for-profit/not-for-profit argument? It's not the same argument?

Mrs Fitzgerald: Not necessarily. The extended care portion that we know now is being amended under the Health Insurance Act so that it will no longer be defined and the service contractual agreement will go from year to year. That's really, I think, the problem we are looking at, because they may decide that they just won't renew the contract.

The Chair: I'll have to move on to the last question; I'm sorry. Ms Carter, you have the final question.

Ms Jenny Carter (Peterborough): Thank you for your presentation. Several presenters have said that they don't like the inspection system that's been proposed and you said that you thought the Advocacy Act now makes that unnecessary. I wonder if you could enlarge on that.

Mr Gingrich: Not totally unnecessary. I've called it the compliance management program. I think that's necessary and I think it's doing the job, to date, that it was intended to do, and I don't believe that we have to go back to the inspection type of model. But certainly residents have the opportunity today for an advocate to act on their behalf if they feel they are not being treated fairly. I just think there could be an overlapping by covering it under this act and also having an Advocacy Act to protect the residents.

Ms Carter: Of course each individual will now have a service agreement with the facility, and presumably if there were any discrepancy as to how he was being treated he could appeal to an advocate on that.

Mr Gingrich: Right.

The Chair: I'm sorry; our time is up, but I want to thank you very much for coming before the committee this morning for your presentation and for answering our questions.

Mr Gingrich: Thank you.

Mr Larry O'Connor (Durham-York): Mr Chair, I might just ask for a clarification from our ministry staff on the compliance review versus inspection and if there is a difference, because maybe that might enlighten the committee as we're getting settled.

The Chair: Okay, very briefly.

Mr Geoff Quirt: I'm Geoff Quirt, acting director, long-term care division. I think it's important to point out that the current Nursing Homes Act doesn't contain the words "compliance adviser," nor does it reference the compliance management program. It still uses the word "inspector," which is the kind of language lawyers like to use to define that function specifically. It's clearly our intention to continue with a consultative compliance management approach, the same approach we use now, even though the legislation now says "inspector."

The Chair: Thank you. I'm sorry; we're here to listen to the witnesses. Comments can be made during questions.

SAINT LUKE'S PLACE

The Chair: I will call on the representatives for Saint Luke's Place to come forward. Welcome, lady and gentlemen. If you'd be good enough to introduce yourselves, please proceed.

Mr Don Attridge: Thank you. I'd like to introduce to you, firstly, Ms Elizabeth Lovely, who is the staff representative of Saint Luke's Place and also the chief steward there. Also here are John Kauffman, our administrator, and George Boniface, who is a member of our board. With that introduction, I myself am Don Attridge, a tenant in Saint Luke's Place.

The Chair: Welcome.

Mr Attridge: I'd like to present to you the feelings of the tenants and residents and staff members of Saint Luke's Place this morning. As I said, my name is Don Attridge. I am a tenant and a board member of Saint Luke's Place and I am here to present some serious concerns of the 154 tenants, 146 residents and 143 staff members of Saint Luke's Place.

We live and work in what we believe to be one of the finest seniors' facilities in the province. Established in 1976, Saint Luke's Place is a non-profit charitable facility for seniors from all walks of life, sponsored by the congregation of St Luke's United Church who donated the land for the building and provided the necessary volunteers for the startup of operations.

As the attached pamphlet shows, it is a well planned and constructed facility where the residents' and tenants' interests are always a priority. That's appendix A.

Since its opening in 1976, the board, all volunteers from the community, set high standards, hired competent staff and has built and maintained a very high reputation for continuum of care provided to its seniors. The fact that I am the president of the tenants' association and a member of the board of directors shows that the philosophy of the board is one of listening and making sure resident concerns are quickly and appropriately dealt with. This is also demonstrated by the highest awards of three years' accreditation received in 1985, 1988 and again in 1991 from the Canadian Council on Health Facilities Accreditation.

The working partnership with the ministry officials has, to my knowledge, always been excellent and very cooperative. The board and its staff are accountable to the community and our seniors through its public meetings, especially the annual meeting where the board of directors is elected and the budget or bylaw changes are approved, as shown in the minutes of the last 1991 annual meeting, attached as appendix B.

As you may sense, we are very proud of our seniors' facility, the open manner in which it is operated and the continuum of care it provides. When we moved in as tenants—and I would like to stop and say "we" here is my wife and I—we knew we would be able to live in this facility regardless of what care we were going to require, except for acute hospital care. The apartments would allow us to remain independent as long as possible. If temporary care was required, the staff from the home for the aged would be able to provide it and, if permanent care became necessary, we would not have to leave our spouse or friends and move to another facility but could move into the home for the aged or a nursing home attached. The sense of security that comes from knowing this is very important and most comforting.

It is therefore most disturbing to us that the present government has introduced a bill that seriously threatens a number of values we have worked very hard to obtain. The most threatening of these is the suggestion in section 5 of Bill 101, where the minister will designate a placement coordinator who will have the authority to decide when and where we will go and when care requirements force us to move from the apartment into care.

This appears to threaten our previous understanding. It looks very much like we will be entirely dependent upon an outsider making the decision of when we will be eligible to move from the apartment to the care section of Saint Luke's Place or, worse, he or she has the power to force us to accept another locality.

We chose to live at Saint Luke's Place because we share its philosophy, the participation and input at the

volunteer board level; the excellent care provided in the care section. Bill 101 appears to remove this security and freedom of choice. This is going backwards many years and must not be allowed to happen. We urge you to please carefully reconsider the language in Bill 101 giving such powers to an appointed individual.

The other consequence of this section of Bill 101 appears to be that the volunteer board of directors may become redundant. They could lose control of effectively governing the facility, since they may have no say as to who will live in the care sections or what level of care can responsibly be provided.

0940

Saint Luke's Place, as its mission statement points out in appendix C, has a volunteer board committed to care for its seniors and staff and are determined to act as advocates for the elderly. They have done so most successfully in the past 16 years, having gained a reputation for being most sensitive to us seniors and accountable to the public for all their actions. It is most disturbing, therefore, to think that the government would appear to be saying that the board should hand over their keys to a government-appointed individual and become subject to inspections by an inspector to see whether the regulations were precisely observed.

The great strength of Saint Luke's Place is its individuality and pride in being different. The input of many hours, expertise and dollars from volunteers who personally take pride in providing the best care stands to be lost if the incentive of being different, independent and free to progress in the interests of us elderly is removed and replaced by a legalistic system of regulations and inspectors.

The operations of Saint Luke's Place have been open to the public. We have been and are accountable to the government and the community. We do not need to waste taxpayers' dollars on a new system of rigid regulations and inspectors whose primary concern is to see that regulations are met.

Regulations denote a minimum standard. As such, they remove the incentive to staff to give their best, for the tendency in a legalistic system is to make sure the law is observed to the letter, leaving less interest or energy to provide above and beyond what is required. Surely, accountability is necessary, but where that exists and evidence shows that the residents are very content and happy, why introduce a system that encourages sameness? Why make a home that is operating beyond the minimum standards without additional costs conform to a lower standard? We will all lose.

We think Saint Luke's Place is different where we, as seniors, are allowed to be different, where we can be ourselves, where we can arrange our rooms the way we like with our own furnishings, except for the mattress and drapes because they have to be fire-retardant—we understand that. Don't make us put all our beds in the same way with a dresser and bedside table that matches. Leave us our dignity and self-respect to make choices and decisions as much as we are able. Strict legislation has a tendency to remove this and makes us into robots. Surely that is not what redirection of long-term care is about. This, in our opinion, would be misdirection.

I have taken considerable time of this committee and I appreciate this, yet there is one more point I wish to make.

In the last two years the facility has had to lay off staff because of lack of funding. The result is a decrease of some services to our residents. Under the proposed funding system there is nothing to indicate an increase of funding, yet some residents will be required to pay more—rumours are, up to \$300 or so per month—yet seniors who stay in their homes will receive the services required for free, whether they are able to pay for them or not. Are we, as seniors in facilities, being asked to subsidize those staying in their homes? This brings a question to mind: Is our quality of care being underfunded to allow for free home care? It would certainly appear like this.

We don't know yet the exact amounts people are going to have to pay in facilities for care, but whatever it is, why should people in their own homes also not pay if they're able?

In summary, we make the following recommendations:

- (1) That the role of the placement coordinator be one of assisting in coordinating placement in cooperation with the administration of the home who retains ultimate liability for the care given.
- (2) We urge that the coordinator be legislated to respect the seniors' choices.
- (3) The legislation must allow the facility to retain its distinctive mission and difference, be it an ethnic, religious, cultural or geographic distinction, with the ability of residents to progress in a continuum of care in the same facility.
- (4) Do not allow the legislation to destroy most valuable volunteer input and enthusiasm by overlegislation and an inspection system that will create legalistic institutions where the seniors individuality and freedom of choice becomes secondary.
- (5) Let the funding system be fair to everyone, whether they are in a facility or their own home and where government funding is required. Let it be adequate for the quality of life we require.

In closing, please do not ever allow us to go back to the old stigma that was attached to senior facilities not so many years ago. I thank you for allowing me this time for a presentation on behalf of the residents, tenants and staff of Saint Luke's Place.

The Chair: Thank you very much. I think we've just had a few presentations by tenants' associations and we really appreciate your coming and sharing your thoughts with us. We'll start the questions. If I could just remind members of our tight schedule today and perhaps impose the Speaker's rule from back home: one question, one supplementary. If you're subtle and skilful, who knows what you can work into those two questions, beginning with Mrs Caplan.

Mrs Caplan: A good choice. I hear well your concern about questions. We've heard the same thing. I know you were here for the previous presentations so I won't repeat the questions, although in your answer to my one question and one supplementary I'd appreciate it if you would comment on the discussion from the previous presentation around those areas you've addressed in your remarks as

well—compliance, other approaches and particularly the statement of principles.

My first question really would be to ministry officials or to the parliamentary assistant. I know the parliamentary assistant is a lawyer as well. I would like to ask why the ministry, in response to everyone who has come and said terms like "inspector" are outdated, outmoded and so forth, is not considering more up-to-date modern legal language when everyone is asking you to do that. This new legislation is an opportunity to really change and be forward looking and we know we find new words, new language and new definition all the time in legislation. It seem to me that the government is being stubborn in a way which is not necessary. All the time you have court interpretation dealing with new language in terms such as "total quality management" and "continuous improvement." Words like "compliant management" are now common in our language. I think this might be an opportunity for the government to be a little more progressive and change the language to reflect what we're hearing from people. Are you willing to consider a change in language in this legislation?

Mr Wessenger: As I understand your question, you're not asking us to change the basic concept of insuring accountability, and in the system you're asking a question of just the words that are used rather than the terms that are used. Is that correct?

Mrs Caplan: What you're hearing is that language is very important in the message it sends out in legislation, and so the language becomes important as to the response you're going to get. Everyone agrees there has to be accountability; you've heard that from every presenter, but everyone is also saying find new language we're more comfortable with that is not the adversarial old style. I'm asking you if you would consider finding that language. It has been suggested and recommended. You've heard these people say it and presenters before them.

0950

Mr Wessenger: I certainly am prepared to look at other language. I will ask counsel to indicate, though, whether they think there are any problems in that. As we're all agreed, we have to have the accountability in the legislation and have the powers in there, but it's the question of maybe some terms some people find somewhat offensive.

Ms Gail Czukar: I'm Gail Czukar. I'm counsel with the Ministry of Health. Another term could be used besides the word "inspector" and the same powers and responsibilities and obligations on that person could be retained in the legislation.

Alternatively, or in addition, the section dealing with quality assurance could be changed. I think there's already been a suggestion made that we're certainly looking at alternatives to the term "quality assurance" to encompass what I understand to be a broader concept of quality management or quality improvement. The answer is yes, we could use different language, and my understanding is that we're looking at that.

Mrs Caplan: My supplementary to the presenters is that what I've heard you say is that just the language

change may not be enough because you would be also concerned about the approach or the duplication since you're an accredited facility as well. Would you feel that within this concept of quality management approach perhaps a mandate for quality management and a mandate for accreditation might in fact be more accountable than the old style inspector as we see it today?

Mr John Kauffman: If I may answer this, I agree very much with you that it would be more accountable, simply because the inspector approach gives us a feeling of someone coming in to look for violations, which is the key word that is used all the time. It sets up an attitude of a negative feeling and a threatening attitude. The accreditation approach is very positive, it is very cooperative and it strives for going far beyond the standards that are set and. It looks to these.

It also has a far greater emphasis on direct resident care than the inspection approach does. The inspection is legalistic with regard very much to the aspects that surround the residence itself. You find the "inspector" coming in to look at whether particular rules are observed rather than talking to and observing the residents. The accreditation approach very strongly strives for looking at how the residents' care is achieved and the aspects surrounding it.

I would also like to comment that I find your principles, what you call the statement of principles, quite acceptable. I think they would be very easy to work with. Again, it sets up an aspect of cooperation that you've suggested.

The Chair: Mr Attridge, did you want to comment on that?

Mr Attridge: Yes. As far as the word "inspector" is concerned, my only comment is that in Saint Luke's Place I feel quite solidly in saying that we have over 300 inspectors in our building. The board, the staff and the administrator—having to sit where I sit in the hot seat between both, I know they don't get away with too much.

The Chair: That's inspection.

Mrs Cunningham: Which shows the total disregard of some people who put things in writing around legislation. They haven't been out there in the real world to know how it works.

My question is with regard to your residents' council. It's so refreshing to have a group like you come before the committee today because when you go back into the history of your own establishment, it was a church group that got it started. You're still there and you're still working on behalf of the citizens. Some of us around this table, my colleague Mr Hope and I especially, are very concerned with this legislation because we want to qualify some day to get into some kind of place where people will take care of us. We talked about that last night.

Mr Randy R. Hope (Chatham-Kent): Nobody will take me.

Mrs Cunningham: With too many rules, Mr Hope and I just would not qualify. We know that, so we're here to make sure.

Mrs Caplan: You would qualify.

Mrs Cunningham: I don't know. Some days I'm not sure. The people of London don't always believe that.

Mr Hope: It's going to be a long time before I'm there, though.

Mrs Cunningham: Oh, I don't know, Randy. You keep going the way you are and I don't know.

Interjections.

Mrs Cunningham: But residents' councils aren't mentioned in the legislation, are not referred to in any way. I'm just wondering what you think about that.

Mr Kauffman: Maybe the president could speak first. **Mr Attridge:** On which?

Mr Kauffman: With regard to the residents' councils.

Mrs Cunningham: Yes. You're not mentioned. This is a form of housing, let's face it. Tenants' associations have all kinds of powers, but here you're not even mentioned

Mr Kauffman: No. From an administrative point of view, I would very much support the idea of having the residents' council or whatever organization you have of residents and tenants and the participants who live there as a part of the facility and its management. We use the tenants and the residents very much in our management decisions.

Mrs Cunningham: Could you advise the committee as to this quality control issue, that this would be one of the groups that would have some say or interest?

Mr Attridge: They definitely have a lot to say in our place. The residents' council meets far more regularly than the tenants' association does. They come up with positive suggestions and the administrator's invited to sit in when there is a controversial item so that he hears it firsthand and then it's taken care of from there by the proper committee.

Mrs Cunningham: We'll be looking for this kind of amendment from government members because this is a group of people—tenants—it's always been very concerned about. We'll look for that amendment. Thank you very much.

Mr O'Connor: I want to thank you for coming here today. It's always a pleasure to hear from people who reside in there so that we can hear their concerns directly. Just taking a look at your brochure, I could see where there are little subcommittees of the residents' council meeting. Whether it be over a game of cards or maybe by the pool table, I'm sure there are ideas that are discussed right there that end up being brought up when the residents' council does get together.

A question I've got and that I'd like to ask staff here—maybe I'm putting them a little bit on the spot here—is that it seems that these people have talked about the fine facility they've got. They're high-ranking in the accreditation process. They've scored in the top three times, which I guess is a tribute to not only the people who help maintain it but of course the residents and pointing out problems before they do become serious.

I guess the question I've got is that, in taking a look at the accreditation process, are there facilities that may be approved through an accreditation process that may actually have a problem? I think what we're hearing is that the accreditation process will work if we stick to that. When we look at the legislation, we have to find out why we wouldn't just go to that, or are there problems with that?

Mr Quirt: Yes, we highly recommend facilities to go through the accreditation process, but from our point of view there are some limitations to that. For example, virtually every nursing home in the province of Ontario is accredited. To me, that doesn't mean that the government doesn't have a responsibility to monitor care in those facilities and it certainly doesn't mean that we can stop inspecting, period, because every one of them virtually is accredited.

Secondly, the accreditation process, as has been demonstrated here, happens on a fairly infrequent schedule. If you do very well, the inspectors or the accreditors don't come back to see you for a period of three years. Certainly with a nursing home, or a home for the aged for that matter, a great deal can change in three years. A nursing home might have three different owners in three years.

Thirdly, as has been pointed out by some presenters, the accreditation process is a process that reviews the facility from the point of view of having the appropriate administrative policies and procedures and having the right committees in place. As I mentioned earlier, it's a very valuable process to go through. Many facilities say that going through the process of becoming accredited is the real value as opposed to the certificate that says you are accredited. As I mentioned earlier, we support it and pay a premium to those facilities that are accredited. However, we do note that it's quite possible for accredited facilities to be problematic from a compliance management point of view. This is in no way a reflection on the accreditation process, but we do often have many complaints from accredited facilities.

From my perspective and, I think, the perspective of my staff, while we highly recommend and value the accreditation process, it's not a substitute for a compliance management program that would respond to individual complaints from consumers and deal with the quality of care side of the equation.

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Mr O'Connor: In following up with that, we heard even earlier today and before that there's a great deal of nervousness out there about the sanction approach. It seems like there's that heavy-handed approach, that the government's going to go in there and place heavy-handed sanctions, and of course it's going to affect the care. Could you comment on the sanctions. Maybe it's similar to an approach that's in place now, but maybe people who have come today would like to hear that.

Mr Quirt: Okay. First of all, I'd be more comfortable with language in the bill that didn't say "inspector." That's the language we have now in the bill, and as these representatives know and the nursing home industry is aware, our approach is a consultative compliance management approach. Sanctions are something inherent in that which we'd use only as a last resort. Our first job is to respond to

a complaint from a consumer or to point out a problem with the operation of a facility, show some ownership over that problem, provide a suggestion on how it might be dealt with and try to be as consultative and collaborative as possible with the facility. Sanctions would only be used when all other efforts didn't produce the desired improvement in resident care.

The Chair: I will just allow anyone a comment.

Mr Attridge: Just as a quick comment, it's not only the word "inspectors" that was referred to by the member of parliament over here; it's the powers attributed to this. You know, a rose by any other name is still a rose, and I would simply like to say that we are concerned over the powers of one individual, and possibly without appeal. This is another thing that's not built into here. We may be told, kind of arbitrarily, what we're going to do, and I don't think there's any place in this day of life for that. Thank you.

The Chair: Thank you. The parliamentary assistant had one point of clarification.

Mr Wessenger: Yes. I note your question on page 6 about saying, is there any difference of treatment between those persons remaining in their home and those living in facilities? I'd just like to point out that people living in the community have their nursing, personal care and quality of life programs paid for. People living in facilities have their nursing, personal care and quality of life programs paid for. People in the community pay their own accommodation, as do people in the facilities.

The Chair: I want to thank you very much for coming before the committee, not only for your brief but also for the various documents you've appended. We appreciate it very much.

Mr Attridge: I made just one error. I forgot to introduce our past president of the board, Bob Pettitt. He was sitting behind me. I couldn't see him, so I forgot him.

The Chair: Welcome, Mr Pettitt, as well. Past presidents of the board are very important.

WE CARE HOMEHEALTH SERVICES

The Chair: We call our next presenter, We Care HomeHealth Services. If you would be good enough to come forward and make yourselves comfortable and, once settled, be good enough just to introduce yourselves for the committee and for Hansard, then please go ahead.

Mr Jeff Hitchcock: Good morning, everybody. My name is Jeff Hitchcock. I'm one of the owner-operators of We Care HomeHealth Services in Kitchener-Waterloo. We're a private duty nursing home health care company. Mr Ron Hoppe, a friend and colleague of mine, is part of the franchise system that we have across Canada. Nationally, we have a variety of offices. Mr Hoppe has been the spokesperson in regard to the agenda that we have brought forward this morning and he's going to speak to some issues that are of paramount importance to us from our point of view, being a private home health care company.

Mr Ronald G. Hoppe: Good morning, Mr Chairman, committee members, ladies and gentlemen. While Bill 101 does not directly impact upon the provision of home health

services with regard to the private sector, I think it's important that we are here this morning in so far as Bill 101 does bring effect to many of the changes in the redirection of long-term care which were stated in the consultation paper that was released some time ago.

To that end, I would like to share a few comments and observations and raise a few points with the committee this morning which we believe to be relevant and related to the overall larger picture with regard to the redirection of long-term care in the province of Ontario.

As Jeff said, We Care HomeHealth Services is a proprietary provider of nursing, home care and family support services in individuals' homes. While the name of We Care may not be that well known in Ontario, as our organization is newer in this province, we have been in business for almost 10 years and are well established in western Canada. In fact, we are by far the largest provider of these types of services in the western provinces.

The issue we would like to focus in on and speak to most specifically this morning is the government's stated preference to utilize only a not-for-profit service delivery model in the provision of home health care services. I think it's also important to say that our company, in appearing here this morning, is not doing so only based on self-interest. It is worth noting, I believe, that at the present time our organization is not involved in contracting with the province of Ontario in any manner whatsoever. Therefore, this proposed change in policy would not result in us losing any business or any revenue whatsoever. Nevertheless, we feel it is very important that we speak to this issue.

At the same time, I would like to preface our comments by saying that we are not here advocating the abolition of not-for-profit service providers. In fact, in many provinces where we operate, we work in conjunction with and side by side with not-for-profit service providers. We support the contributions made by some of these not-for-profit service providers and believe strongly that both commercial and not-for-profit service providers have an important role to play in the delivery of services.

As I said, Bill 101, while not directly impacting upon the delivery of these services, is related to the larger issue which is the redirection of long-term care in the province of Ontario. In undertaking this redirection, the government set forth a series of eight goals which it was hoping to achieve in this process.

Those goals—I'll recount them quickly—are as follows: the integration of long-term care, health and social services, improved access to quality services, creation of community alternatives to institutions, greater consumer participation and control over the services they receive, promotion of racial equity and cultural sensitivity, realization of funding equity across the province, enhanced protection for the rights and security of service workers and a continued preference for the not-for-profit service delivery system.

Again, while we generally support these goals, it is the proposed methods of achieving these goals that cause some concern. Again, specifically, the concern we wish to speak to this morning is that the government's preference for not-for-profit service delivery model appears to us to be based only on political philosophy and that no rational,

empirical or logical reasons have been brought forward to support this position.

If I may indulge the committee for a few moments I'll review some of the reasoning which has been brought forward to support this position. I will admit that these reasons are few; nevertheless, they are all the reasons we've been able to uncover.

Firstly, in June 1992, the Minister of Health indicated to the standing committee on estimates that commercial operators were capturing a disproportionate share of the homemaking services market and that this was taking place primarily in the larger urban centres. Not-for-profit service providers had expressed their concerns that they were then being left to service only the more remote and rural areas where delivery costs were higher.

One question this raises that hasn't been discussed to the best of our knowledge is: Why were the commercial operators capturing a larger portion of the homemaking services in these urban centres? Was it perhaps that they were able to provide these in a more responsive manner? Was it perhaps that the consumer preferred to utilize the services provided by a commercial operator? I think that is a very, very key question that needs to be answered, especially as it relates to the goal of giving the consumer greater participation and control over the services they receive.

With regard to the not-for-profit sector's concern about an inequitable distribution of the workload between urban, rural and remote settings, perhaps a fairly simple solution to that would be to have any future tender specifications require that commercial operators be able to serve all geographical areas. I'm very confident that commercial operators would respond to this challenge and provide services to rural and remote areas effectively and efficiently.

1010

Another issue that was raised to justify the government's position and concern over the utilization of commercial service providers was concerns relating to the Canada Health Care Accessibility Act, those concerns being that the utilization of commercial for-profit providers in fact may be contrary to this act. This act guarantees public administration of universally accessible health care. If this were a valid complaint, what about doctors? They operate on a for-profit basis. What about hospitals that today are contracting out everything from management services to laundry? What about other provinces that contract out a portion of their home care services? While I'm not appearing here this morning purporting to be any expert on the Canada health act, I do know that the issue is not contracting out, the issue is public administration, and no one has suggested doing away with that.

At the same time, during the estimates process in June 1992, the then Minister of Health also had indicated for the public record that, "decisions haven't been taken that will have an immediate impact on the commercial sector." While these comments were being made, at virtually the same time the minister was issuing directives to home care administrators across the province of Ontario absolutely, positively prohibiting them from further utilizing the services of commercial or for-profit operators. In issuing this directive, there was only one slight problem: The Minister

of Health forgot to communicate this to some very important people. This is a point to which I'd like to return in a few moments

Has any other rationale or supporting data been provided by government to support its position on this issue? Unbelievably, none that we were able to find. I note that a legislative research assistant is here this morning and I'd simply like to add to that comment that if this information does exist, it certainly isn't being shared in the public arena.

With regard to the potential impact this decision to support not-for-profit providers only will have on the provision of home health care services, I think this bears a few moments of discussion as well. Certainly, one of the results will be that more responsible taxpaying private businesses will close and with regard to the potential financial implications of this decision, again, government has not provided any analysis in this area. May I suggest that even a cursory review of the day care scenario will foretell the result

What happened in day care? Private operators were forced out; private sector jobs were lost; huge additional expense to the taxpayer; no additional day care spaces. The same fate, I suggest, looms in the area of home care if the not-for-profit service model is pursued. What will happen? Private operators will be forced out; private sector jobs will be lost; huge additional expense to the taxpayer; no additional home care services for the citizens of Ontario. In fact, the day care situation was and is such a disaster that one of the government's staunchest supporters—and I'm referring to the 8,400-plus CAW union members—has listed this as one of six reasons it was considering withdrawing its support for the current government.

Earlier, I touched upon the minister not communicating her position very well to some important stakeholders. While it is one thing for the general public not to be fully informed, here are some comments of two of the minister's fellow NDP MPPs on this issue, remarks made within the last two weeks, some as recently as five days ago. Said one NDP member, "The government, in suggesting that for-profit agencies will be eliminated, is a little premature, it's not going to happen." Said another NDP member—this five days ago—"The government should never have announced this preference for not-for-profit when they have nothing in place to support such comments."

Mrs Cunningham: I bet they're not ministers.

Mr Cameron Jackson (Burlington South): And they won't be.

The Chair: Order, please.

Mr Hoppe: The elimination of commercial service providers will not contribute to the achieving of the stated goals of the redirection of long-term care; in particular, improving the access to quality services. In fact, many quality services today that are available will be eliminated. The elimination of commercial service providers will not achieve the goal of community alternatives to institutions. The community is only an alternative to institutions if it's also economically viable. Certainly, this will not achieve the goal of greater consumer participation and control of the services that citizens receive.

There is one further goal on which I would like to particularly comment. That is on the goal of enhancing the protection of the rights and the security of service workers. While this agenda might be consistent with the general NDP plan, there are a few unique points to consider relative to home care services. The nature of the work is such that there is some fluctuation in the workload. If you are assigned to a client who is receiving 20 hours of service a week and, unfortunately, that client becomes hospitalized or services are discontinued for some other reason, that work will not be available to you in the short term.

To guarantee service providers 40 hours, or whatever the number of hours of work per week, regardless of the client's need, I would suggest, simply might not be realistic. The rights of all employees, whether they're in the home care sector, in manufacturing, in retail—whatever sector they happen to be in, we suggest that their rights in Ontario are already sufficiently protected through existing labour legislation.

In the Redirection document on this topic, the government also expresses its need to provide more training, thereby being able to justify higher rates of pay and increased job security. We respectfully suggest that there's a workforce with the necessary skills and that the issue at the moment might not be one of providing more training to people with lesser skills. Rather, it's an issue of matching the employee's skills with the client's needs. Training qualified individuals currently working as homemakers to be nurses' aides, for example, when there is currently an abundant supply of nurses' aides, somehow seems to be counterproductive.

In conclusion, let me clearly and directly state our opposition to the government's stated preference to use only not-for-profit service delivery agencies. While Minister of Health, Frances Lankin strongly promoted this preference and issued directives to preclude further private sector participation in the provision of home care services. From our perspective it is utterly hypocritical, but sadly indicative of a political philosophy gone mad, that on Tuesday as Minister of Health, Ms Lankin strongly supported a position which would severely harm private home care companies and their employees, and then the next day, on Wednesday, now as the new economic superminister, stand up to the microphone and proclaim that: "improving the NDP's relationship with the private sector and job creation are among (my) top priorities. If we want to create jobs in this province, the private sector has to be a part of that. We have an economy that needs to be pushed."

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With regard to the impact of the government's position and directives on our organization, as I said, we are not currently within the system, so at the moment we don't stand to lose any existing opportunities. However, to comment fully on this topic would provide enough material for a further 30-minute presentation. However, it is sufficient to say that in a province that prides itself on providing equal rights for all, extra special rights for groups claiming to be disadvantaged and extremely extra special rights for politically expedient socialist causes, it is inconceivable to us that a legitimate, qualified, taxpaying corporate citizen

such as our organization would be precluded by a whim of government from competing for contracts when other similar private companies are entitled to preferential treatment for no other reason than that they happen to be there first. Thank you.

The Chair: Thank you very much for your submission and for coming before the committee. I just remind members that we are tight for time—one question, one supplementary, hopefully tight. I also remind the members that we're here to listen to the deputations. There will be plenty of place for vivid discussion among ourselves in the Legislature. We'll begin with Mr Jackson.

Mr Jackson: Jeff, Ron, thank you very much for your presentations. It was a bit of a breath of fresh air as you discussed the realities of health care in this province, which are that if our focus is to make our system as accessible as possible with choice, then we have to have an arrangement under regulation that accommodates the private sector, because there is not a study existing anywhere in this country which shows that government can do something less expensively than the private sector.

Having said that, I just want to reinforce my political party's support and my colleague's and mine with respect to—we assisted in building the system in this province. We believe the partnership with the private sector achieves two things: increased access points and a responsible use of taxpayer dollars because of the balance and the blend between private and public services.

Your analogy is so absolutely appropriate. We have seen several handicapped organizations come before us asking why the government broke its election promise of creating pilot projects which empower handicapped individuals to purchase their own services yet this government has plowed \$200 million down the toilet, frankly, to expand day care facilities when day care centres are closing as fast as the government can build and reopen them. As you noted, there are fewer day care spaces today in Ontario than there were a year ago.

Mr Hoppe: It is sad to say.

Mr Jackson: We just don't want their made-in-Havana day care policy to become their made-in-Moscow home care policy. I commend you for your presentation and appreciate the clarity with which you presented.

Mr Drummond White (Durham Centre): I'll try to avoid responding to my friend—

Mr Jackson: You'll get no argument that way.

Mr White: —because his idea of health care is of course made on Wall Street. But regardless, the issues that you bring up I think are very valid. I have some friends who run some services like your own.

Mrs Caplan: Are they still your friends?

The Chair: Order, please.

Mr White: Yes, they are very much still my friends. Those issues have not been dealt with adequately. I certainly am aware of the public statements that you referred to. However, that's in reference really to your sector. In reference to the private nursing homes versus the not-for-profit homes for the aged, my understanding is that the

Ontario Nursing Home Association is very much in support of this legislation because it brings nursing homes up to the same level of funding and footing for their ongoing expenses as the not-for-profit sector. This is a totally different situation in regard to the institutions than it is for those services in the community. While I agree with your concern as being valid in your arena, in this arena it's quite the opposite. Here we have this made-in-Havana policy which is actually bringing for-profit centres on board. Mr Jackson's language may well apply in your area, sir, but not in regard to the homes for the aged and the non-profit sector. In fact, it's the not-for-profit sector, the homes for the aged, that were so regularly saying, "Why are you doing this to us?"

Mr Hoppe: With all respect, I will grant you those views. I started out my presentation by indicating that I was not here this morning to comment specifically on Bill 101, realizing that this is primarily what it's dealing with. Rather, I was wanting to comment on the specific area of home health care services as they are a part of the larger redirection and Bill 101 is facilitating many of the things that are encompassed in that self-same policy of redirection.

Mr White: In the minister's statement she very clearly indicated that there'll be no attempt to change the balances we presently have. In fact, it brings things up to standard.

Mrs Caplan: The action doesn't fit with the words.

The Chair: Order, Mrs Caplan.

Mrs Caplan: She said one thing and did another.

The Chair: Order.

Mr White: I hope we will hear more from you, sir, when we move on to long-term care direction. This is only the first phase of it and I hope you'll remain an active participant in the process.

Mr Hoppe: I appreciate that invitation and I can assure everyone present here that you will hearing more from us. As the time is short, and with respect to the time, perhaps we could pose one question to members of this committee. It's a question that we are certainly most anxious to receive some sort of answer to, and that is the question I raised in my closing remarks. That is, time and time again we hear that government hasn't taken a decision, that a final decision hasn't been made, that it's the status quo, that the commercial sector isn't being adversely affected. Here we are. We're looking to expand in Ontario. We're looking to create jobs. We're looking to rent office space. We're looking to do all kinds of things that business activity generates. The question of qualification doesn't arise.

We're equally qualified, as or more qualified than any existing service provider, yet it is this self-same government's directive—apparently it's not a policy; perhaps the difference needs to be explained to me—that despite our qualification, despite our abilities and despite the fact that no decisions have been taken, we are to be arbitrarily precluded simply because we weren't here last year, we weren't here the year before.

Again, in this day and age of equal rights for all and extraspecial rights for some, we aren't appearing this

morning requesting your sympathy or your support. We aren't here requesting favouritism. We aren't here requesting extraspecial treatment. We are here simply pointing out that we are experiencing some frustration at being treated less than equally.

Now, could someone provide us with some reasonable explanation as to why this is the case? Morally and ethically, it's an issue. Perhaps it's even an issue legally. We're not going to start getting into big legal hassles with the province of Ontario. The market for our services is huge and we can pursue that elsewhere. Nevertheless, it is important. We are frustrated and it appears to us to be highly, highly unfair.

The Chair: Thank you. Ms O'Neill, last question.

Mrs Yvonne O'Neill (Ottawa-Rideau): I am very pleased that you have highlighted the contradictions surrounding this whole matter. There's a great deal of uncertainty. Business plans are totally in jeopardy. That was brought to our attention here last night. The only solid evidence we have in writing is that there was a press release in December that stated there would be a preference for non-profits. Other than that, everything has been verbal.

We are members of the Legislature. We have very accurate knowledge. I presume you belong to the Ontario Home Health Care Providers' Association. Certainly we meet with these people and have every right to and want to be very well informed of their needs. They have attempted to meet with the minister and that's not been possible, even though it's an umbrella organization representing literally thousands of people in this province. That's very, very distressing when we know that there are things going on, when we know that there are movements within the Ministry of Health indeed to look at solely not-for-profit providers.

I'd like to ask you two things, because we've had people who are in agreement with the government come before us and some of the accusations they make are that your staff are not well trained and do not do a good job. I would like to know what profit or, as I would consider, small business people do to train their staff, to have that on the record. I'd like to ask you, have you seen—and I'm not sure of the municipalities that you are in across the province—any change in the relationships you are having to municipalities as well as the one you already mentioned?

Mr Hoppe: With respect to your first question and these complaints that for-profit staff are not well trained and are not doing a good job, I think such a broad comment is utterly unfair.

Mrs O'Neill: I agree.

Mr Hoppe: Within the for-profit sector there may have been some bad staff from time to time, as there has been in the not-for-profit sector. This is, again, a discussion that could go on for the whole day.

What steps are being taken from our side in our sector to ensure that staff are appropriately trained, that staff are doing a good job? First of all, it's our perspective that a high priority in providing safe, effective care is the appropriate matching of the skill level to the client or the patient's need, ensuring that quality assurance programs

are in place and are being followed. I know from firsthand experience that the private sector is now in possession of very advanced technology which enables the cost-effective, safe provision of care services in the most efficient manner ever possible.

With regard to the second question, if you could perhaps just—

Mrs O'Neill: Have you noticed any change in your relationships with municipalities since this uncertainty has developed around your—

Mr Hoppe: Again, I would simply say that being a new organization and trying to become established with some of the municipalities, the only effect that we have noticed is one of tremendous confusion in talking to the municipalities, receiving absolutely contradictory responses to our questions from people across the hall from each other in the same department, receiving absolutely contradictory answers from a superior to one of the workers, and that's only in the situations we are able to get any information at all.

The Chair: Thank you very much. I regret that our schedule means that we have to close off.

Mr Hoppe: We respect that and we look forward to a future opportunity.

The Chair: I think you have put a number of questions before the committee. We will be considering those. Thank you again for coming.

Mrs Caplan: I would like to correct the record.

The Chair: Just one moment, please. I just want to call the next witness and then we'll deal with that. Would the representatives from the community and government relations committee for Region 3, Ontario Association of Non-Profit Homes and Services for Seniors, be good enough to come forward.

Ms Caplan, you wish to correct the record, very briefly.

Mrs Caplan: Yes, thank you. A couple of days ago, Mr Chairman, I referred to a meeting that took place between the Ontario Home Health Care Providers' Association and the government. Inadvertently, I suggested that that was a meeting with the minister. I want to clarify that it was not a meeting with the minister because the minister had refused to meet with this organization. In fact, she refused to meet with them even after being directed by the Premier to meet with them.

The meeting was held with a policy adviser from the minister's office and a policy adviser from the Premier's office. The statement I made was that the message from the government to the association at that time was that there was no place for the delivery of home health care services, or in fact health services, by the private sector was the policy of the government. Further, at that meeting the negative message to the private sector was that by directive they had already begun to move to instruct municipalities not to use the services of the private sector. I wanted to clarify that for the record.

The Chair: Thank you for that clarification.

ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

The Chair: Gentlemen, welcome to the committee. If you would be good enough to identify yourselves for Hansard and then please proceed with your presentation.

Mr Robert Pettitt: My name is Robert Pettitt and I'm the chair of the community and government relations committee for region 3. With me are David Rudy, representing St Joseph's Home in Guelph, John Kauffman from Saint Luke's Place in Cambridge and Brian Ayer, a board member from St Joseph's Home in Guelph.

As indicated earlier by a previous presenter, I am also the past chairman and a member of the board of directors of Saint Luke's Place in Cambridge.

The Chair: You're welcome in both capacities.

Mr Pettitt: Thank you, sir. I want to emphasize that I'm here on behalf of the volunteer boards of directors of 23 non-profit homes which form our constituency, so we represent elected and volunteer board members as opposed to staff and residents. Not that our interests are any different, but we do represent that constituency.

As we've indicated in our presentation, our committee is comprised of elected and volunteer board members of homes for the aged in region 3 of the Ontario Association of Non-Profit Homes and Services for Seniors. Region 3 encompasses the geographical regions of Halton and Waterloo and the counties of Bruce, Dufferin, Grey, Huron, Perth and Wellington.

You will notice that we've listed the number of volunteer directors associated with the board of each particular home on the first page. Region 3 includes 23 non-profit operating homes for the aged with 3,032 beds, seniors housing programs and other services which assist seniors who live in the community. Collectively, these facilities would average over 50 years of service for each home.

As we age, our lifestyle choices are increasingly limited. They can be physical, financial, cognitive or a combination of limitations. With the present emphasis on maintaining the elderly in a community setting and utilizing scarce community services, choices are becoming even more limited. It appears that the choice to become a resident in a long-term care facility may not be available. Concerns such as loneliness and various psychosocial disabilities ought to be accepted as legitimate admission criteria for an approved long-term care facility.

The new proposed standards for facility admission tend to dehumanize seniors in need of care and support because they appear to remove the element of choice to determine when, where, how and with whom to live, socialize, spend their time, their money and to be able to exercise their right to die with dignity. In the proposed system, the placement coordination service will have the final word in determining what a senior's needs are and where they can best be met.

Even though the proposal gives lipservice to the importance of input from the senior, as long as the agency has been given the final authority of when, how and where to live, the senior will be left to the mercy of the system without recourse or an equitable and expeditious appeal

process. The proposal leaves the senior open to abuse by either having to remain in his or her own home against any expressed wishes, or being placed in a facility which may not be of his or her choice. The legislation must respect the right of choice of the senior in making the final decision.

While the proposed standards indicate a PCS structure as having final authority in determining the placement of an applicant, it must be recognized that the admitting facility requires the authority to determine if the care needs of an applicant can be safely met, since that facility has that legal liability.

For several years, government documents have encouraged residential alternatives. A number of facilities have responded by providing a wide range of services for seniors in facilities on the same site. Proposed legislation does not recognize the right of residents to move to other levels of care located on that site which are also part of the continuum available to them in that supportive community.

Saint Luke's Place is a specific example of continuum of care where we have apartments, residential care and extended care. The facility allows people to move from one section to the other as their care requirements increase.

1040

With respect to funding, there are a number of concerns centreing around the funding issues which are as follows: The new funding ignores the principle of funding care based on demonstrated need. The proposed funding system simply redistributes the currently available funds, with a small increase in resident contributions in a different way. It is a reallocation of underfunding and not of funding enhancement. It will reward those who have provided limited services and penalize those who have developed a wider range of services.

Many municipalities and charitable corporations will be required to continue their current levels of contribution. In many cases, non-profit providers will have to increase their share of funding as the province freezes its contribution. Municipalities currently contribute about \$90 million and charitable organizations raise about \$20 million annually just to cover the operating costs of their homes, because provincial grants and resident fees are not sufficient to cover their costs.

Government statements indicate that resident contributions will increase by about \$150 million, but in reality they will simply replace withdrawn provincial funds.

If assets are not included in the residents' maintenance payment calculation, or are not available for recovery from their estates, then general tax revenues will be required, even though the resident might well be able to meet that additional cost.

The province is contemplating a completely changed approach to capital funding. It must be recognized that if long-term care facilities are not able to develop any surplus in their operational budgets, there will need to be funds generated, either through an adequate depreciation factor or through grants which are sufficient to meet equipment and building capital costs.

In its Redirection of Long-Term Care paper of October 1991, the present government stated, "Funding to nursing homes and homes for the aged will be increased to improve

services for residents and to ensure that increasing care requirements can be met effectively." If funding of anything less than the 1992 average cost per resident day is implemented, there will be the following effect.

Facilities with operating per diems of under the average will be able to provide enhanced programs that many other facilities cannot afford.

In homes with operating per diems of over the average, services will not be enhanced, but will be reduced and staff lavoffs will occur.

The average extended care per diem cost in homes for the aged in the province of Ontario for 1992 is \$102.73.

As such, our recommendations are as follows: Placement coordination services, along with facilities, must be given joint decisions, making responsibility for placements according to need and ability to meet the need. Facilities, especially those operating under the Charitable Institutions Act, must be able to continue to maintain their distinctiveness and their long-established mission. Seniors must be able to access facilities for personal reasons, such as cultural, emotional and social reasons. Recognition of the continuum of care and the right of choice for residents to relocate on the same site is imperative. Facilities must be given authority to maintain maximum capacity.

The option must be provided for residents to request and receive services above those which are regulated by government, if they are able and willing to pay the costs for those enhanced services. The allowable per diem for funding purposes must be increased to at least \$110 to recognize the reality of current operating costs. We must provide an economic adjustment factor for the red-circled portion of funding to homes in order to allow them to shift the emphasis on the services they now provide. We must provide one-time grants to charitable organizations, allowing them to eliminate accumulated deficits and start with a clear slate. We must allow a sufficient depreciation factor to provide for the replacement of capital equipment and building replacement.

We must commence within the first quarter of 1993 a recognized workload measurement study to determine accurately the care costs to be used in setting funding levels, allowing the government to meet its stated mandate of 1991. Lastly, assets and income should be used in calculating the residents' contributions toward their maintenance fees. Thank you, Mr Chair.

The Chair: Thank you very much for your submission and also for listing at the front the various homes within your group. We'll begin the questioning with Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. My first question is with respect to—as you are aware, there are differing care levels in different institutions throughout the province of Ontario. Do you think it's fair that people with similar care requirements receive different-type services throughout the province?

Mr Pettitt: Do we think it's fair that they receive different—

Mr Wessenger: Different services, as is presently the case. Do you think people with similar care requirements should receive the same level of services?

Mr Pettitt: I think generally that would be the case; they should receive the same services.

Mr Wessenger: The next question I would like to ask you—as you may be aware, some institutions provide exceptionally good care in the province, but it's been estimated, for instance, to bring up the level of care to that provided in Metropolitan Toronto at the average home for the aged would cost approximately \$800 million, which would be a substantial amount of increase in taxes to provide that increase. I ask you to just consider the aspect that the only practical way of trying to deal with this is to try to bring up those at a lower level on a gradual basis to meet the level of those at the higher level, I would suggest, otherwise you are looking at a substantial infusion of money into the whole system.

Mr Pettitt: I guess the alternative to that is to reduce everybody else to the lowest common denominator and that's what we're trying to avoid as well.

Mr Wessenger: We do not want to see the individual—that's why there's no reduction in funding for the high level of homes.

Mrs Caplan: I don't like to repeat a lot of the points I've made before with other deputations, but you have mentioned a number of things that have been mentioned before. I want to know if you would support an amendment that would permit long-term care facilities to refuse an admission that was required by placement coordination on the grounds that it was an inappropriate placement and care could not be provided, provided there would be the right of the client to appeal that, or the right of the placement coordination service to then appeal, so that you would give the choice to both the provider, the institution, as well as to the client who was looking for an appropriate placement. I think what sometimes happens is that somebody may want to come to you and you don't believe you can really provide that care for them. Do you think that would be a better approach than what exists in the legislation today?

Mr Pettitt: I think it's a step in the right direction, yes.

Mrs Caplan: Did you hear the statement of principles?

Mr Pettitt: Yes.

Mrs Caplan: Would you comment on that?

Mr Pettitt: We would take some comfort in the addition of a statement of principles, because it does address the element of choice.

Mrs Caplan: Would you like to see it in the legislation, as opposed to in regulation?

Mr Pettitt: I prefer it in the legislation itself. I think part of the difficulty in dealing with Bill 101 is that there are so many sections of the act that refer to "in accordance with the regulations." We haven't seen the regulations and we have no idea what the regulations are going to include. I always have a great fear of government or legislation by regulation.

Mrs Caplan: I agree with you that excellence cannot be legislated. I don't think behaviour can be legislated. I think generally enforcement models don't work. If you want accountability you have to find the kind of environment which will encourage people to take pride in what they do and then stand accountable through either a process of accreditation or a process which requires a quality management program to be in place, and that only if there is an inability to meet these standards set by the accrediting agency, or if there is a complaint which is then founded, should the government be able to take action. I wonder if you would support that kind of an approach, rather than the big stick enforcement approach this legislation seems to be imposing.

Mr Pettitt: We'd certainly be in favour of that approach.

Mrs Caplan: Is that what you have in place now?

Mr Pettitt: Pardon me?

Mrs Caplan: I'd like you to compare that with what you have in place now, or how you've changed in the last little while.

1050

Mr Pettitt: Our experience as non-profit homes operating with the Ministry of Community and Social Service in the past has been one of cooperation and partnership. I think that's the type of atmosphere we would like to encourage and see carried on as opposed to one of enforcement or an adversarial type of situation. Our fear is that we may be moving towards the latter.

Mr Jackson: I appreciate the clarity of your recommendations and the way they're set out. On recommendation 3, earlier you were present and you heard the reference to day care. I want to talk about this issue because it's of concern to me. The leading indicators of stress for seniors have to do with the wellness of a spouse, a move or the passing of a spouse. These are the three most significant issues around stress for senior citizens. The notion is that in many of your facilities there is a continuum of access to the various stages of care, comfort and accommodation. This legislation doesn't provide for the protection that you'll be able to maintain your relationship with your spouse in the same location.

If I use the day care analogy—this is why your response earlier about how these kinds of protections have to be entrenched in legislation is imperative—are you aware that under day care rules this government has brought into place as of very recently any subsidized day care space requires that the child has to go to a non-profit centre? You have cases where in a family of two or maybe three children the policies of the government specifically divide families and force a child to go to one centre and the brother or the sister to go to another centre.

Given that this government has already brought into place policies that divide families, we are having difficulty taking its word that it's going to protect senior citizens in a similar fashion. I'd like you to comment about the need for entrenching in legislation, with proper language, protection for spousal relationships and continuum of care and placement to ensure that their needs are met, because certainly this

was a major decision for a government in North America, to specifically have a policy that divided families and separated them. Since we've had a precedent from this government, we don't want it repeated now with senior citizens at the other end of the spectrum.

Mr Pettitt: When St Luke's Place was built in 1976, it was encouraged to establish a continuum of care. Originally the facility had apartments and residential care only. We found that as our residents aged we required extended care and we then moved into extended care. We have had a number of situations where spouses have come into the apartments and one of them, for whatever reason, may have required more care and then has gone into residential or the extended care wing of the home. It allows the spouses to maintain a relationship because they're still in the same physical location or building. It's extremely important that we maintain that choice for them. Residents come into our home expecting that this is going to be their situation, knowing that if one of them requires more care he or she is not going to be separated from his or her spouse or moved to another facility unless it means he or she has to go to the hospital, which he or she knows is unavoidable. My response would be yes, continuum of care has to be entrenched. That's why it's one of our specific recommendations.

Mr Jackson: I appreciate that, because there's medical evidence that the health of the healthier spouse diminishes rapidly when there is this forced separation, when they were anticipating being close and accessible. Many of the facilities in my community have this continuum program, and the notion that when you're finally moved you're in place.

My final question has to do with recommendation 12, and that has to do with assets and income. We're not getting much commentary before this committee on this, but you have, and I appreciate that. Some have cynically suggested that the government is moving strictly to an income test, because it is anticipating doing a brand-new tax on seniors' assets for survivor benefits—and this is a huge tax that's coming—and by calculating assets at or near a time when the Treasurer is looking at taxing them for another purpose is at cross-purposes with the government's desire to grab more revenue. That's what's cynically been suggested here, but I appreciate the fact that you've noted that assets and income should be calculated as opposed to the government simply saying, "We'll look only at income and not at assets when determining fees." You may want to expand on that based on your experiences with your charit-

Mr Pettitt: I think our approach is that we're looking for a system of fairness and equity. Fairness and equity mean that assets as well as income must be taken into the calculation, otherwise it's conceivable that somebody could have considerable assets that are earning no income that could in fact be used to pay for his or her care and not be a burden on the other taxpayers in the province.

The Chair: Thank you very much for being with us this morning and for your presentation.

Mr Pettitt: Thank you for the opportunity.

ST JOSEPH'S HOSPITAL AND HOME

The Chair: I would now like to call the representative from St Joseph's home for the aged. While they are coming to the table, I would like to note for the members that we have received a brief from the Dufferin Oaks Home for Senior Citizens. I believe they are here today. They're not on the schedule of witnesses but they have brought a brief. I've asked the clerk to circulate that to all the members so that their written comments will be part of our record.

We want to welcome the representatives from St Jospeh's to the committee. We have received a copy of your presentation. If you'd be good enough to introduce yourselves to the committee and for Hansard, then please go ahead.

Mr Brian Ayer: Thank you, Mr Chairman, and good morning. Good morning to the MPPs and ladies and gentlemen. With me are the president and chief executive officer of St Joseph's Hospital and Home in Guelph, Sister Margaret Myatt, and the vice-president and administrator of our home, St Joseph's in Guelph, Mr David Rudy. My name is Brian Ayer and I'm a trustee of St Joseph's Hospital and Home in Guelph.

The board of trustees of St Joseph's Hospital and Home wishes to express its support to this government, as well as prior governments, in initiating long-term care reform to replace a number of programs with one act of legislation. More importantly, we are supportive of the concept of providing services to the disabled and older persons who are able to maintain residence in their own homes.

The Sisters of St Joseph's of Hamilton established a home in 1861 in Guelph. Since that time, St Joseph's has met health care needs of the community in an acute and chronic care hospital and, for older people specifically, in a home for the aged. That service has been available to anyone, regardless of race, colour, religious persuasion or ability to pay.

Along with other non-profit homes for the aged in Ontario, St Joseph's has been able to work with the government on a partnership basis and has developed programs and facilities which support the changing needs and desires of the older population of our community. During the past 10 years St Joseph's has assisted people living in their own homes through its outreach programs. The Out'N'About day care centre assists many frail elderly people who are still living in the community, some alone and others with children. The therapeutic program provides stimulation for the body through exercise activities, various craft programs and mental stimulation through educational and recreational programs. A nutritious noon meal is also provided.

The Alzheimer's day care centre provides support to the person who has been diagnosed with an Alzeihmer's type of dementia or other cognitive impairment. The goal is to maintain an optimum level of physical, mental and social functioning for each participant. The program offers support and relief to the care giver and assists in delaying institutionalization. Family members can bring the participant early in the morning and pick him or her up late in the afternoon, enabling care givers to be gainfully employed,

if necessary. This innovative program is designed to meet the needs of the participant rather than requiring the participant to fit into the parameters of the program. Will a legislative solution to long-term care allow the excellent and innovative leadership that has been in place? We wonder and doubt it.

1100

St Joseph's Home is an accredited facility through the Canadian Council on Health Facilities Accreditation and has recently received a three-year award for a survey held in November 1992.

With the proposed implementation of long-term care legislation through Bill 101, we are very concerned with the authority which is given to the placement coordination services without apparent accountability. PCS agencies will have the final word in determining the senior's needs and how they can best be met. The goal is to keep seniors in the community. Even though the proposal addresses the importance of input from the seniors, the PCS agency has still been given the final authority over them. We will be left to the mercy of the system by removing the element of choice. These choices are made from a holistic perspective. This proposed legislation deprives the individual of the right of choice based on his or her physical, psychological, spiritual and social needs.

Placement coordination service, as it is proposed, will be able to admit persons to a long-term care facility and the facility cannot refuse to admit that applicant without any consideration in terms of the facility's ability to provide the staffing to adequately meet the care needs of the individual. The facility will only be able to have staffing levels to the point where revenue levels meet operating costs. Will the placement coordination service share in the legal liability which a facility assumes in caring for its residents? Who will be accountable for the residents placed in the facility?

For the past five years the increase in funding has not kept pace with increased operating costs, most of which are not within the control of the home; namely, arbitrated awards, pay equity, increased Workers' Compensation Board assessments and other legislative impositions. Wages account for over 75% of operating costs. The proposed funding level does not allow adequate staffing levels to meet the care needs of applicants to the home, most of whom present with cognitive impairments as well as physical disabilities.

Because of an antiquated building and a long distance to the dining room and activity areas, over one half of the residents in St Joseph's Home require wheelchair support. All reserves have been used to meet operating costs and no funds are available for major building renovations or equipment replacement. We have appended some financial data. The current proposal does not relate funding to the level of service which is required.

The government has stated that, "Funding to nursing homes and homes for the aged will be increased to improve services for residents and to ensure that increasing care requirements can be met effectively." It is common knowledge that the average per diem cost in homes for the aged in Ontario is above \$102. Is the government committed

to ensuring there is funding to meet "increasing care requirements" or will case mix index funding be based on available dollars? If the latter is the case, then we are looking at a program of warehousing the elderly.

When the government of the day decided to license the profit-making nursing homes, it implemented an inspection system to ensure that regulatory standards would be met. The statutes were revised and are viewed as placing the facility in a confrontational position with respect to the ministry responsible for the inspection process. For over 50 years, the non-profit homes for the aged have worked together with government on a partnership basis to develop a program which recognized the primacy of the individual as being paramount with respect to one's dignity. security and self-determination. Operating boards of management, directors or trustees, elected or appointed by their communities, are held accountable for the operation and management of each particular facility. The information is public and the goals are in the best interests of the residents. Part of the trustee's task is ensuring the quality of the program for which they are responsible. At St Joseph's this is accomplished in conjunction with the process of the Canadian Council on Health Facilities Accreditation. where each facet of the facility is measured through a quality assurance-risk management function. Imposing an inspection compliance system does not guarantee quality; it will simply ensure adherence to minimum standards. Excellence cannot be legislated.

Mr Chairman, it is not our intent to be supercritical of the proposed legislation. We do feel, however, there is erosion of the principle of voluntary governance leading to less autonomy and flexibility of governing boards to determine the nature and purpose of their organization as well as its policies and direction. The ability to be creative will be stifled. The proposed legislation appears to be very restrictive rather than enabling, and the concept of governance and authority of the voluntary board will be seriously undermined. The control the government appears to be assuming will not be in the best interests of the elderly who are dependent on the social system of this province.

We respectfully request the following amendments to the regulations under Bill 101 be considered prior to third reading in the House.

- (1) Bill 101 must balance the principle of accessibility with the need for a high quality of life. Therefore, the placement coordination model must give due consideration to each person's preference.
- (2) Bill 101 must also recognize the right of facilities to make informed choices in the best interests of the applicant and their current resident population. Therefore, appropriate access to an appeal mechanism must be guaranteed.
- (3) Utilize a recognized workload methodology to determine accurately the care costs to be used in setting funding levels.
- (4) Provide one-time grants to homes for the aged which will operate under the Charitable Institutions Act, allowing them to eliminate accumulated deficits.

(5) Abandon the concept of inspection in all non-profit homes through enhancing the role of ministry program supervisors.

We support the government's commitment to longterm care reform. Very important are regulations which identify resident contribution, plus a methodology of funding which will be adequate to meet the care needs of the residents who live in our facility. It is important that the redirection be done right the first time.

May I ask, then, we go to the final page, which provides a very abbreviated financial statement relating to the prevailing conditions at our home.

If we examine the equity in the home at March 31, 1984, we had \$944,883. The estimated equity in the home nine years later—\$524,320. There has been a substantial run-down of our equity base which cannot be allowed to continue. We have created in the past year a substantial cash deficiency which, you will see reported at March 31, 1993. was \$170,000.

We believe at St Joseph's we have a responsibility to our residents to operate our home in a fiscally responsible manner, so that their presence, their comfort, their peace of mind can be ensured. We feel we have been invited by government to provide a level of service that government, in fact, has not been prepared to fund.

Perhaps if I could close, Mr Chairman, by inviting all the creative MPPs here—if they would look back, there are questions on, I believe, pages 3 and 4—one which addresses mix index funding. The other concept we are particularly concerned to report back to our board of trustees is the concept of legal liability with respect to placement of residents in our home. Hopefully, the imaginative MPPs here, without going to supplementary, can roll those both into one question.

The Chair: Thank you very much. I think this is the first time where, very skilfully, the witness has turned the questions back on the members, but rightly so, and I noted those as we were going through. Thank you very much for that. We'll move to questions and perhaps answers as well. We'll begin with Ms Fawcett.

Mrs Joan M. Fawcett (Northumberland): Thank you for your presentation. I think that is an excellent question you pose and possibly some of the ministry staff will be able to give you an answer. We wonder and doubt about the very things you wonder and doubt about. There is no doubt about that.

If I could just ask, though, you've gone through the classification system, I would assume, and I'm wondering how you found that. We've had some concerns expressed to us that perhaps the Alberta system doesn't fit Ontario, and I wonder whether you thought it really suited that. Also, whether you feel the funding that will result from that is going to be adequate or whether you have some concerns around that. Are you suffering from hardship because all of this has been later than you expected it to happen? We have been assured that March is the magic month that you possibly will hear about the level of funding, and yet I have also heard that maybe it won't be ready until next September, so those are all concerns.

1110

Mr Ayer: I will ask Mr Rudy to respond to that, but I would say our plans at St Joseph's were based on an expectancy that long-term care funding would be in place January 1.

Mrs Fawcett: Right.

Mr Ayer: It's a matter of grave concern that these financials speak for themselves. It's a matter of grave concern to us that the matter then—in fact, March, as you have said, Miss Fawcett—the concern becomes ever greater if in fact that funding is further delayed. It's imperative that the funds—I suggest microcosmically that the statement we produced is not much different from statements of other charitable homes in the province, and the level of underfunding from our point of view, speaking as a trustee, is absolutely intolerable.

With respect to your question, I'll ask Mr Rudy to deal with it, please.

Mr David Rudy: Thank you. In terms of the classification process, I think if it were done today, you would find the level of care that is evident in the residence is much different than it was last fall when it was done.

I guess this addresses the question in terms of the people referred by PCS, as well the change in people who are there. So there's a great concern, not only that the funding for the classification mix might be adequate, but that the level of care will increase or can increase quite dramatically between the period of time when classification is done. Of course, the staffing patterns will be set, as we said in the brief, on the basis of the funding that's available, so that leaves cause for great concern.

Mrs Fawcett: It concerns me too. Thank you very much.

Mr Jackson: I will leave to the parliamentary assistant and his penchant for getting advice from legal counsel to answer your second question. However, I have no doubts as to where the liability lies and government has an uncanny ability of making sure everybody else has liability and not it.

However, having said that, I want to commend you for raising an issue which is perhaps the most difficult, central issue around long-term care, and that is about the difficulty in making decisions about giving the needed care, or care based on the needs of an individual versus what the government says we will fund, because government has decided that's all the dollars we have. That simple statement speaks to the major tension which exists in long-term care in our province.

I've not said this for the record, but I am going to today, that particularly Catholic or charitable homes for the aged are having a great difficulty with this dilemma. It's perhaps in its very humanitarian or Catholic nature that these homes desire to operate on a model which recognizes these quality-of-life issues, and quality of life means something a little different than what is being thrown out at these public hearings. Quality of life has a much more significant issue in a Catholic hospital, as it does in a Catholic home for the aged.

Now, without overstating that, I'm one of 10 children who were brought into the world by the Sisters of St Joseph's in Hamilton, so my mother can speak at length about that issue. I want to ask you, because I think it's at the root of your first question, about how you are prepared to deal with the issue of a regulatory framework which says these are the limited dollars you have in terms of how you will meet the needs of those residents versus your mission statement and your motivation for service and care, and whether you're going to be able to deal with this contradiction, given the legislative framework as it is before us today. I hope the Sister will have an opportunity to

Mr Ayer: She certainly will.
Mr Jackson: Thank you.

Mr Ayer: We are concerned. We have decided at St Joe's that our mission statement is important and very critical to our responsibility to our patients. Anathema to us would be the concept of warehousing our residents. We would prefer to close down rather than face that as an alternative.

What is so discouraging to us is to provide the level of care specific to each resident. Our concern is to provide that level of care as efficiently, as compassionately as we can without concern about—we run our hospital, our home, as efficiently as we can. Our concern always is our patient in the context and as described in our mission statement.

We talk about the fund mix specific to the question you address. Our concern is that there is not sufficient planning. We don't see information that satisfies us in Bill 101 that addresses the specialized needs, the specialized extra cost. We don't like to even talk about that in terms of care.

The cost and the level of funding—and Mr Rudy and Sister can talk about the hours involved depending upon the requirements of each patient. There does not seem to be room to address the increased needs, therefore increased costs. Our concern is to provide the highest level of quality of care to our patients and residents. We're extremely distressed that the process of doing that—it would seem it's going to be aborted by the shortfall of funding that we understand may in fact prevail when Bill 101 is finally dealt with and passed and brought to parliamentary passage. Sister.

Sister Margaret Myatt: Thank you. In the hospital and the home, which are both on our site, the method of funding is quite different for both, and therefore the ability to control costs in the hospital is different than the home. In the hospital we can close beds, cut services and our expenses go down, the revenue will cover. In the home, of course, the funding is quite different. If we do not have patient days, we do not receive revenue, so that's on a very mercenary level. The two things are quite different.

However, as Mr Ayer has said, our philosophy would not allow us to provide either warehousing, as it's quoted, or inappropriate level of care per patient or resident, and therefore our board has taken a stand, and the Sisters support it, that if the funding is not adequate in the future, the home will indeed be closed. Over the years, and we've been on the site there over 130 years, we have not restricted access to the institution, either in the hospital or the home, based on ability to pay as one criterion only. In that sense we have, as well as other charitable homes—I'm not saying other charitable homes don't do the same thing—run up an increased deficit, for which we are solely responsible.

The Sisters have been very generous in supporting that deficit. We have fund-raising campaigns. We do all those good things to try to offset our deficit. It is becoming increasingly difficult, if not impossible, to do that. We're at the point now where we're at a critical decision, even though in Guelph, as you probably know, the plan for us to rebuild on the site a new long-term care facility is in place. If the funding is inadequate for that new facility, let alone for the current one, I'm not sure what it holds for the delivery of long-term care in Guelph. That's a big unknown at the moment.

Mr Jackson: Thank you very much.

Mr Norm Jamison (Norfolk): Thank you. I notice that many of you are here as part of more than one delegation. That shows the umbrella of the network out there.

I'd like to really address your first recommendation that deals with the placement coordination system and your concerns around that. I'd like to inform you that the placement coordination approach is intended to ensure access to those persons in greatest need. The current system we have does not really ensure this. Many in homes could be served in the community, for example, while people in great need of facility care remain in their home today. The access system itself, I think, through the process of these hearings, will also promote consumer choice—I think it's important that I say that today—including responsiveness to cultural and spiritual preferences. Amendments to the legislation are under consideration so that this may be made more clear. The system will also ensure that people will be placed in facilities which can meet their needs. That's the purpose of the facilities' right of refusal. The placement coordinator will also assist the prospective resident by providing a single point of accessing the system and by providing greater information on the choices available.

1120

Finally, it's important to note that the placement coordination system will promote the efficient use of beds by giving priority to those in greatest need. More people in need will be placed and this will reduce the demand for the funding of new beds. This in turn, I think, conserves funds for community service expansion. That deals with the whole funding situation also. I just wanted to say that because I think that by saying that some of your concerns may be addressed in that light.

With regard to the question on funding, we have to realize also that in many cases currently some residents live in nursing homes or homes for the aged with funding levels of approximately \$78 whereas others with the same needs live in homes for the aged with funding levels of \$135. That's an inequity and has to be seen as that. As to the red-circling, there are going to be infusions of money. Certainly they haven't been announced clearly at this

point, but the total levels have. Again, making the system more fair to everyone and as equal as possible is a very important point in dealing with long-term care.

Mr Ayer: That would suggest to me, and perhaps I didn't hear correctly, that each resident's level of need should be treated the same way.

Mr Jamison: No, that's not what I said.
Mrs Caplan: That's what you said.
Mr Jamison: I just clarified it.

Mr Jackson: On a point of information, Mr Chair: Could we get a copy of what Mr Jamison just read? It would be helpful to the committee and maybe even to the deputants if we left copies here so they can hear what the government is saying.

Mr Jamison: Those are my notes.

Mr. Jackson: Oh. I can see-

Mr O'Connor: They are recorded in Hansard, of course.

Mr Jackson: Oh, okay.

Mr Ayer: May I ask, did I hear then that amendments that are being brought forward will allow the resident a choice and will also allow the institution a choice? I would like to be clear on that please, Mr Jamison.

Mr Jamison: Through sitting and listening clearly to the whole placement coordination question, those points have been made clear to the committee.

The Chair: I believe the parliamentary assistant had asked to clarify a number of points which included those, so perhaps, in terms of a number of questions that have been asked in pursuit of enlightenment, we will now turn to the parliamentary assistant.

Mr Wessenger: Thank you, Mr Chair. Yes, I'd just like to make a few comments. I certainly do understand your concern about funding. The only thing I can say is that certainly the charitable homes for the aged will be the major benefactors with respect to the increased funding to the institutional sector. I don't know how that will relate to your particular institution, but as a general group they are certainly going to benefit the most as a result of the increased funding.

With respect to the question of the placement coordination, I think it would be helpful if we had some clarification at this time for all members of the committee, as well as yourself, about how the process is likely to work with respect to the more detailed mechanism for resolving disputes when you have a situation where a facility doesn't feel that a patient is suitable, that it can't service that patient, and the placement coordinator feels that the facility should take the patient. I believe this will be set out in the program manual, if I'm correct, but that information isn't available yet. I might ask staff to indicate to the committee and to yourselves how that process is likely to work.

The Chair: If I might, just before Mr Quirt begins, when that's completed, if you wish to ask a question or make a comment, feel free.

Mr Quirt: If I might, I'll address the specific question that you had about an amendment. Yes, an amendment is

under consideration to make the intention of the bill more clear. It was always our intention that placement coordinators would recognize, and to the greatest extent possible respond to, client preference, client choice. No one has to go into a long-term care facility if he or she doesn't want to, and the first question that placement coordinators will ask is: "Which facility do you wish to go into? Please indicate your choice so we can put you on the list for the facilities that you wish to be considered for." Client choice is clearly the driving factor in the placement coordination system.

First of all, the placement coordinators would be required to determine if someone's eligible for long-term care placement. In that process they would be required to make sure that consumers were making an informed choice about not only facility options in their community or elsewhere, but also community service options that they might not have been aware of previously. Placement coordinators would then ascertain which facility a client wished to go into. That might be the facility next door or it might be one with a particular ethnic or religious environment half the province away. The placement coordinator who relates to a particular facility would then be responsible for ensuring that every resident who has expressed an interest in getting into that particular facility gets treated fairly in terms of access to that facility. Only those people who have expressed an interest for a facility would be considered for admission there. The placement coordinator would then look at the list of people who have said, "I wish to get into your facility or another facility", and in a fair way determine who needs that service the most.

In the program manual there's a description of people who are in an emergency situation. It talks about people who might be in the hospital vis-à-vis people who might be at home. If you're eligible, a combination of the urgent nature of your need and another factor of how long you've been waiting would be taken into account to determine who fairly got access to the next bed available in that facility.

Clearly, the placement coordinator's job is to determine whether you really need to be in a long-term care facility, to determine whether you and your family understand the options available to you and to determine what preference you have once you understand what the options are in your community. As you're well aware, many seniors would not know the difference between a nursing home and a home for the aged, know where they were or what type of environment they offered. Once that information is provided, the consumer chooses the facility he or she wishes to be considered for and the placement coordinator determines from the list of people who have expressed an interest for each facility what's fair in terms of who should have access first.

There may be situations where the placement coordinator would have to say, "I know that you really want to get into St Joseph's home for the aged, but there's a waiting list of probably three, four or five months there and you might be able to get into your second choice a little sooner," and allow a client to make a choice in that respect.

One other possibility under this new managed system is that someone might go into the facility of his second choice and not lose his place in in line for their facility of his first choice. That's not a possibility now in the system

and it's certainly not a possibility across the province. It's possible under the new system for a person who wished to go into a German Lutheran home, for example, in Kingston to know about the fact that there is one in Niagara and to be considered fairly for admission, regardless of where he happens to live in Ontario.

Mr Aver: Mr Chairman-

The Chair: There is one further point from the parliamentary assistant.

Mr Wessenger: I understand, Mr Quirt, there's a dispute resolution process. I wonder if you might comment on that.

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Mr Quirt: At this point in time, if a placement coordinator determines that someone is not eligible for admission to a long-term care facility after the person's health status, functional ability and community living situation are considered, that client who has been deemed ineligible has the right of appeal currently. The other right to appeal that's contained in the act, the right that's related to this, is the right of a facility to refuse to admit someone on particular grounds. Those grounds will be prescribed in regulation and protected in regulation.

There are two examples that members of the committee have used and we have used to illustrate how these regulations might appear. A situation where a facility did not have the structural environment that would allow, for example, for a resident who had a cognitive impairment and tended to wander to be protected in a secure environment would be one example of a reason why it would be quite legitimate for a home to refuse admission. The second example might be that a prospective resident required a particular nursing procedure or treatment and the staff of that facility had yet to acquire the skills, had yet to develop a policy on delivering it safely.

Those are two examples. As we've mentioned many times, we would expect that placement coordinators would not refer clients to the facility unless obviously there had been some dialogue. The placement coordinator wouldn't be doing his or her job properly if he or she were making a lot of referrals that facilities had to refuse to admit.

Mr Ayer: Thank you. That did answer my question.

The Chair: Were there any other comments that you wished to make on any of those—

Mr Ayer: Yes, the liability question was one that's important to address.

Mrs O'Neill: You are not the only one who has asked it, either. I think it would be great if we could get that cleared up. A written statement on that would be better.

Mrs Caplan: And also the question on the clarification amendment on the right of facilities to refuse on the basis of inability to provide appropriate care and then define it more clearly in regulation. Are you considering that as well?

Mr Quirt: At this point it's my understanding that the act allows us to specify the reasons in regulation why a home can refuse. I'm of the opinion at this point in time that such an amendment to the act wouldn't be necessary

because we now have the right to define in regulation the reasons why a home would refuse.

Mrs Caplan: But we've heard from so many presenters that they don't feel that's adequate.

Mrs O'Neill: The legal liability.

Mr Ayer: Is there a point of reference in the act that we can refer to that says that?

Mr Quirt: We'll give you that reference in a moment; we're just looking it up. On the question of legal liability, I'll ask our legal counsel to comment further, but it's my understanding that the liability would not be altered under the new system. There's a certain liability held by the home now with respect to the services that it provides to residents in its care. We don't anticipate that liability would be changed dramatically. I'll ask counsel to comment further on that.

Ms Czukar: The reference with respect to homes refusing to admit a person on grounds specified in regulations is in subsection 9.5(6) with reference to the Charitable Institutions Act. I believe that if you're a charitable home for the aged, that's the one that would govern you. It just says, "An approved corporation maintaining and operating an approved charitable home for the aged shall admit a person who meets the requirements of subsection (5), unless a ground for refusal of admission prescribed by the regulations exists." The grounds that would be prescribed are the ones that Mr Quirt mentioned, subject to changes in wording and so on.

With respect to the legal liability question, I understand from page 4 of your presentation that your question—you can tell me if I'm wrong here—relied on an interpretation that your home would be required to have people placed there whom you did not accept or whom you felt you weren't equipped to serve. I think that's been clarified somewhat. In any event, the legal liability would rest with the corporate body that's responsible for providing the care to the resident and not with the placement coordination service if the care is actually being provided by the facility.

Mr Ayer: So we're covered to the extent that we do have a right to refuse, or at least to have that case heard if we felt such a liability were in fact before us.

Mr Jackson: You would have to appeal.

Ms Czukar: In any event, no one can be forced to go to a facility against their will, so if a person didn't wish to be placed, they wouldn't be there in terms of the facility being able to determine whether they could adequately serve the person or not. That is provided for in the section I mentioned, yes.

Mr Ayer: In detail.

Ms Czukar: The detail will be in the regulations.

Mr Jackson: You understand faith very well. You will have to take them on faith.

The Chair: At that point there will perhaps still be a few questions but we've run out of time and we'll have to move on. We want to thank you very much for coming and for your questions.

Mr Ayer: Thank you, Mr Chairman.

ELLIOTT HOME FOR THE AGED

The Chair: I now call the last witness for this morning, the representatives from the Elliott Home for the Aged, if they would be good enough to come forward. Please make yourselves comfortable. We have documents that have been circulated to the members of the committee and if you would just first introduce yourselves and then please go ahead.

Mrs Ethel Doughty: Mr Chairman, I would like to introduce people of our delegation: Miss Marion Featherstone, a long-time resident of the Elliott home; Mr David Hicks, the administrator of our home and Mr Murray Maxwell, who is at present the chairman of our board of trustees of the Elliott home.

My name is Ethel Doughty and I am speaking to this committee today from several perspectives, but primarily as a community volunteer board member of the Elliott, a charitable, non-profit home for the aged in Guelph. I am appointed to this board by both Guelph city council and Wellington county council. I now have well over 20 years experience as a community volunteer in the long-term care sector. For three years I sat on the board of the Victorian Order of Nurses, a vital community service agency.

When our regional health council initiated the placement coordination service for Wellington-Dufferin, I was asked to represent homes for the aged on the advisory committee charged with setting up the service and putting it into operation. I chaired that committee for two of the five years I was a member.

Since both my mother-in-law and my father were residents of long-term care facilities, I also see the system from the perspective of a family member. I need not remind anyone here that we are all potential clients of the long-term care program and I should like to think that in our planning we try to relate more to the ever-increasing number of Ontario residents who are today's as well as tomorrow's clients.

I should like to tell you a little bit about our home. The Elliott has been an integral part of the Guelph community for almost a century. It was originally established as a home of the friendless by a bequest from a Mr George Elliott. That home operated from 1903 until 1963 when the present Elliott opened on a seven-acre site adjacent to the Guelph General Hospital. The Elliott is unique in that it is a charitable organization without a supporting charity; it is truly community based.

Many people in Guelph trust that the Elliott will be there for them if or when the need arises. Unfortunately, we were unable for many years to keep up with our waiting list. Now, of course, the placement coordination service keeps all waiting lists.

In an effort to address a demonstrated need for more seniors' housing in our area, the Elliott board, with the enthusiastic support and great personal involvement of the home's administrator, David Hicks, planned and developed a 78-unit life-lease apartment building. The Ellridge opened in 1987. The Ellridge residents live completely independently but can obtain some services such as meals or emergency medical care from the Elliott.

In 1991, in order to provide more supportive seniors' accommodation and possibly shorten our Elliott waiting

list, another project was undertaken. This building provides supported independent living and opened in September, 1992. These residents require minimal care and are served the main meal of the day in their dining room. If desired, other meals are also available. Each unit has a kitchenette with a small refrigerator. There are, of course, no stoves, but small appliances may be used. Basic house-keeping is also provided. Once again, we utilize to the fullest the energy and expertise of David Hicks.

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We now have a complete continuum of care in a nonprofit setting, ranging from independent living to the full range of nursing home type care in the Elliott Home for the Aged.

Our expectation all along has been that residents would be able to move within the complex to the appropriate level of care with a minimum disruption of lifestyle. So far this has been working very well. This continuum of both residential and care options has for many years been advocated by research in long-term care. It has also been encouraged by various Ontario government policies such as the community residential alternative program. This continuum of service choices on the same site does work.

Page 20 of Bill 101 states that a person may be admitted to a home for the aged only if the placement coordinator has determined that the person is eligible and has authorized the admission of that person to the home. Since the placement coordinator is responsible for keeping all waiting lists and juggling priorities, it can be seen that the implications for continuum of care facilities are considerable.

In preparing this presentation, I went back to the Redirection paper released in October, 1991 and on which Bill 101 is based. Two points caught my eye immediately because I had previously identified them as being very important.

The first point is, "Seniors and people with disabilities want meaningful choices in order to live with dignity and respect." The underlining of "choices" is mine.

The second point is, "How do we ensure that a coordinated system of service delivery does not become another layer of bureaucracy?" After reading Bill 101, my first comment is, "Good question."

These two points, among others, cause me great concern, both as a board member and as a member of the community. I refer not only to the immediate community where I live, but to the Ontario community as a whole.

On the subject of choices, in 1968, when it became necessary for my father to seek admission to a home, our family looked around and we chose the Elliott as a place where he would be able to live with dignity and respect. The building had a homelike atmosphere, both outside and inside. We found it to be spotlessly clean. The administrator and staff obviously really cared about the residents.

In the quarter of a century since then, there have been many physical changes at the Elliott. There have been building upgrades and extensive renovations. However, the basic characteristics of the home, the principles on which we base our philosophy of care, have not changed.

Having worked with our local placement service, I have always felt that this service served a useful purpose.

Primarily, it can provide information about the long-term care system to people who are becoming involved for the first time. It can help people access appropriate community services.

As our placement coordination service was originally set up, clients were assisted in whatever help was appropriate. However, if a client chose to seek placement in a facility—and people rarely do this until they feel unable to cope for whatever reason—the PCS would find the optimal placement for that client, taking into account many relevant factors. Placements were not finalized until the client, the family and the facility were all satisfied that the placement was appropriate.

I think the new system is supposed to work like this, and I am quite reassured from hearing the comments from the gentleman opposite, but in reading the Redirection paper, I find that placement is not really a choice, it's more like a last resort.

Page 39 of the Redirection paper tells us that every other possibility for care must be explored before placement can be considered. It appears that the social and emotional needs of the client are very low on the list of considerations if, in fact, they come into the picture at all. Should not these very personal needs deserve greater priority?

If an applicant is deemed by the placement coordinator to be ineligible for placement, there is a cumbersome and probably lengthy appeal process to the director and even to the minister. Can you imagine putting an 85-year-old or a 90-year-old through this traumatic experience?

There are people who would choose to move to a care facility for reasons of loneliness, anxiety or who find living alone, even with community services, more than they can handle. It concerns and saddens me that based on Bill 101, as I read it, such people could, and probably would, be deemed ineligible for placement and be denied admission to the Elliott or to other similar facilities.

There are other non-profit homes in our area which are as unique in their own way as the Elliott. For example, many Roman Catholic seniors hope to become part of St Joseph's home if and when they require facility care. I understand that approximately 50% of the residents of St Joseph's Home are Catholic. The home reflects this in its care and its programs.

Wellington Terrace in Elora is a municipal home and again unique in that its resident population has a predominantly rural background. I would surmise that each home has a uniqueness which makes it a real home for its residents and they have chosen to live there.

Most homes have auxiliaries—groups of volunteers from the surrounding community whose makeup reflects the cultural, ethnic, religious or other background of the homes. These volunteer groups are very important. Not only do they raise significant amounts of money, but they provide a link between the residents and the community. They sponsor entertainment, outings, craft programs and provide a special service to the home. Our auxiliary also operates a tuck shop for the convenience of the residents.

The Redirection paper tells us that cultural and ethnic diversity is to be maintained, but I wonder how much

diversity can be preserved when the proposed regulations attempt to make every home do everything the same way.

On the subject now of bureaucracy. The Elliott is managed by a board of community volunteers. We have had a whole spectrum of business and professional people on our board: bankers, professors, accountants, physicians, professional engineers, clergy and so on, all with useful expertise and experience. The focus of a board of a non-profit home is on providing the best possible care and quality of life for the residents with the resources available.

I would not cast any aspersions on the for-profit homes, but is it not obvious that a shareholder board must have a somewhat different approach and an added dimension to its focus? In spite of this difference, nearly all the provisions of Bill 101 apply to all facilities, non-profit and for-profit alike. The wording of the bill suggests that the proposed long-term care system will be top heavy with bureaucracy. It attempts to force uniformity on all homes for the aged and nursing homes.

The bill focuses on accountability, documentation, inspections and penalties. I tend to find the tone threatening and suspicious. I wonder, do the creators of this document assume we will all do bad things unless we're threatened with penalties.

Over the years we have worked to make the Elliott a caring home for our residents where each one is acknowledged as an individual, each receiving whatever care is required. Bill 101 looks at each resident as the subject of a plan of care, all aspects of which must be documented. How do you document a hug from a staff member for a resident having a bad day? How do you document emotional support, or is this not a part of care? According to the new funding arrangements such emotional support is not recognized.

The Redirection paper asks, "How do we avoid another layer of bureaucracy?" In institutions receiving government funding, a certain amount of bureaucracy is inevitable. We're accustomed to that, but the new system is piling on an incredible amount of paperwork in an attempt to do what? Impose uniformity at any cost? The term that comes to mind, and you've already heard it several times this morning, is "warehousing."

No one from government has come to our home and asked the board, "Does this home work?" Or, "Do you need help to make it work better?" We should like to ask, "Where is the data indicating that all this documentation, inspection, etc is necessary in our non-profit home?"

Do you know if the residents at the Elliott are happy? As board members, we know they are. Are their families pleased with the care? Yes, they are. Will a compliance officer, who posts a compliance notice in our lobby, make residents happier? Will requiring residents to have the regulation chair or eat the regulation meal make them happier? When will resident happiness, satisfaction and family support be measured? Traditionally in our society satisfaction is measured by complaints that are examined and, if valid, corrected. Do you have such a study of complaints from residents and families to show the degree of required change? May we see these base data? Bill 101 is heavy with inspections, compliance and penalties, but where are

the references to government assistance and cooperation or resident happiness?

1150

You may have bureaucratic data on compliance with regulations, but where are there any direct data on the happiness and satisfaction of residents and families? This is the real purpose and value of a community-based, unpaid board of dedicated trustees who have real authority. Bill 101 does not appear to give this authority for such local and informed boards of trustees. If residents and their families are happy and pleased with their care, why not recognize that fact and give authority to such unpaid community boards to set policies that continue such happiness?

As mentioned earlier, Bill 101 is heavy on inspections, especially inspections of documents. This assumes—inaccurately, I should say—that if something is not documented, then it was not done. What if it were done, but due to cost constraints staff time was not available to record it thoroughly? We have already experienced the first major example of this inspector style. Last September-October there was a provincial survey of resident care. Government nursing assessors entered every facility and spent several days examining records but never asked residents if they were happy or satisfied.

We can count and record such things as medications. food, staffing levels, inventories, but that does not reflect a home. In your own private home someone could inspect your records to ensure that you paid for the hydro and gas, that you have four chairs at each table, curtains the approved length in each room, but are your children and spouse happy? There is no category on government care level surveys to provide funding for such real issues as 30 minutes with a grieving resident who is distraught over a son's divorce or a best friend's death. This is the difference between a home for the aged and an institutional warehouse for the aged. Please, if changes are required, make them with more heart and less bureaucracy, with more local citizen responsibility and authority, and provide for assistance from government consultants when the local board requires help.

In conclusion, we realize that provincial governments have been trying for many years to improve the long-term care delivery system. We also realize that in today's economic climate any change is extremely difficult.

The present government obviously wants to hear from the citizens; otherwise you people would not be here today. We suggest that you also listen. Listen to the clients—the frail elderly and the disabled—who are among the most dependent and vulnerable people in our society. If they choose to live in the larger community, that's wonderful. Then they must be provided with adequate services efficiently delivered. If they choose another lifestyle, then they should have the privilege of doing just that.

Listen to the professional care givers, who have been dealing with the problems of long-term care for many years. Their knowledge and experience can help the system work. We are accustomed to working creatively and productively with government staff. In this regard we wish to express our appreciation for the cooperative support which the Elliott has received from our program supervisor and

his colleagues in the Waterloo office of the long-term care division. This cooperative and consultative style works well and should continue. With real cooperation among all the interested parties, all of society will benefit.

I should now like to ask Miss Featherstone, a resident of the Elliott, to share her thoughts with you.

Miss Marion Featherstone: Dear committee members:

You know my name already, Marion Featherstone. I am a resident of the Elliott Home for the Aged. In my earlier years I was a registered nurse. Yesterday, I celebrated my 91st birthday. I am honoured to have this opportunity to speak to you on behalf of the residents of the Elliott.

We, the residents of the Elliott Home for the Aged in Guelph, wish to draw your attention to the fact that the Elliott is a real home for us. We are very happy with the way it operates. The Elliott board of trustees is very caring. We are pleased with the home-like atmosphere,d we know the Elliott is different from other places and we want this to continue. We are very concerned that the government inspectors will want changes. Please, if changes are required, our board and staff are quite capable. We are also concerned that government inspectors are not only unnecessary for a home like ours, but add a totally unnecessary expense to our lovely province that already has too much debt.

The Elliott is a popular choice of Guelph and district senior citizens and there is always a waiting list. We believe that these are the reasons:

The management and staff are efficient and caring. We have 24-hour nursing service. We have comfortable semiprivate bedrooms and attractive lounges. We have the freedom to come and go as we wish. We do not feel cut off from our former community activities. We feel safe at the Elliott. We have well-planned and wholesome meals. We have excellent housekeeping and laundry facilities.

The Elliott doctor is available when needed or we may choose to have our own doctor. The activities coordinators supervise and direct a hobby and crafts program and also group exercises, games, music, special events, as well as communion and non-denominational Sunday afternoon service in our lovely chapel. Also, the Elliott auxiliary takes an active part in the welfare of the entertainment of the residents. They operate a tuck shop and tea room for our convenience.

While on the topic of why we freely choose the life at the Elliott, we wish to change a common misunderstanding; namely, that we are more independent when we live in a house or apartment with Meals on Wheels and various home care facilities. This is not true and I would like you all to know that. We feel trapped and lonely. We find ourselves alone many hours during the day and night, often unable to cope with daily problems and worries. We do not want to be a burden on our community. We love it here at the Elliott. Before changes to places like the Elliott are ever considered, why do you not come and ask us if we want them?

The problem seems to be that decisions are made in Toronto by younger government people who never come to talk with us. You may have received a few complaints from other places, but not from the Elliott, as far as I know. If

you did receive a few complaints from other places, why not give more places the chance to work out their own problems without government interference? If residents in that place are still unhappy, then make some changes just for those places but not every place.

Since moving into the Elliott, we enjoy the security and independence that comes from knowing that we are free to come and go as we like, without any worries or personal needs. This is how we feel about the Elliott. It is not an impersonal institution. Rather, it is a real home with all the comfort and convenience but without the worry. Please do not allow this to change. You would not want your own home to be the same as every other house and have this enforced by government inspectors. Neither do we want our Elliott to be forced into becoming the same as every other home for the aged and nursing home.

The board and staff are doing a fine job. If this ever changes, we will be the first to know because we live here. We will work with the board and staff, who care for us very much. If this fails, then we, the residents, will let you know, but until that happens, please, no changes. Please, the next time you decide to consider changing the rules about our home, talk to us first and not after you have already gone so far with so much time and expense in preparing a new book of rules that is not needed or necessary.

Thank you for listening to my letter. We hope it has helped you to understand that not all seniors are the same. We cherish our difference. Thank you very much.

The Chair: Thank you very much, Miss Featherstone. I know I express the wish of the committee when, one day late, we all wish you a happy birthday and many more.

Miss Featherstone: Thank you.

The Chair: We'll move to questions. If I could just draw to members' attention that time is tight, we'll begin with Mr Jackson.

Mr Jackson: I won't have a question. I think we have an excellent brief, so I simply wish to say, if I may, to both Ethel and Marion, thank you for your heartfelt comments and thank you for sharing with us the statement which jumps out at me in this brief, "If changes are required, make them with more heart and less bureaucracy." On behalf of the seniors, I thank both of you for giving that message to us very clearly.

1200

Mr White: Thank you very much for your excellent presentation. I'm very impressed that we have a wide group of people: a resident, board member and a director. It's a rare phenomenon when you have a group of people that close and who will work that well together.

The issues that I have concern with are the very things you brought up. You read this legislation and it talks about powers, inspection and this shall happen and that shall happen. What concerns me is that I know that's not what has happened. We've had it clarified time and time again about how this will work, but when you read it, it scares you. For people like you, who are living in a facility like that, when you hear about this sort of thing, it scares you because this is your home.

Miss Featherstone: Thank you. We feel it is.

Mr White: I just want to assure you that from everything I know—and I have worked for five years in a home for the aged, every day, met with the 95 people who lived there; prior to changing jobs that is. I still go back there regularly and listen to them. I feel assured that this legislation is going to improve people's lot, but that's not how it reads. It reads like powers and things like that. I hope we can improve some of that language so that you can feel that assurance, so that people like yourselves who are in that situation won't be scared and uncertain about your future. Thank you again for your presentation.

Mrs Doughty: Mr White, I read the bill through and it's not what I would call a good read.

Mr O'Connor: Legislation never reads well.

Mrs Doughty: It refers mostly to amendments to already existing regulations and already existing bills, like the Charitable Institutions Act, the health care act and so on. For this reason, we have a little difficulty really being sure of what's intended because of, as you mentioned, the way the bill reads.

Mr White: The language of the original legislation is probably just as bad.

Mrs Doughty: I was afraid of that.

Mr White: There are so many pieces of legislation being worked up here, aren't there? But the intent is to improve services.

Mrs O'Neill: I want to thank Miss Featherstone and Mrs Doughty for their presentation. We've had many of these points brought up before, but I doubt with as much eloquence. The Elliott has brought forward its points with the right people this morning, I think.

I'm very impressed with the way you kept reminding us that there's a real great difficulty with this legislation in its intent to impose uniformity. We certainly feel that way. We hope there will be changes that will be sensitive. We have been given some small indications. You also talk about a threatening tone. Whether it's staff or residents, we've had that expressed often before.

I'm very happy that you brought forward your experience of the fall when the inspection or survey of the homes took place and none of you was questioned about your level of happiness. In my mind, that shows some very great disrespect for people who feel very supportive of the environment in which they live and want to be able to express that.

I don't know whether you've had time to examine the other legislation, the legislation that is now passed but has not been proclaimed, regarding the Advocacy Act and consent to treatment. I don't know whether you've done that in your residents' council, but your suggestion, Miss Featherstone, that complaints be the basis for actions by government in homes would be one that I think would be much more congruent with the Advocacy Act than what is suggested as a method of inspection in Bill 101. I wonder if you've examined that at all or how you feel the complaint system could work, and if you haven't, would you?

Miss Featherstone: We have one board member in particular, a physician, who is extremely concerned about

the implications of the Advocacy Act. I'm sure that in some instances it's a very useful piece of legislation, but maybe it should be looked at from the point of view of family members and so on to make it more satisfactory to the general population.

Mrs O'Neill: Do you see it in relation to Bill 101 at all? Have you thought about how the complaint mechanism could work for you rather than the imposing atmosphere of Bill 101?

Miss Featherstone: It's mentioned in the redirection paper, at the bottom of a page, and I think that would have to be looked at very carefully, actually, in order to incorporate it into Bill 101.

Mrs O'Neill: Please keep looking. You're doing good work

The Chair: The parliamentary assistant has a final comment

Mr Wessenger: I certainly thank you very much for your thoughts. I certainly know how homes for the aged contribute to such a home-like atmosphere for their residents, and it sounds like yours is one of the best. One thing I'd just like to elaborate on is that I know people say language isn't suitable, it's outdated. One of the problems with the situation is that amending legislation is very difficult, cumbersome and complex, but even more difficult than amending legislation is creating new legislation.

What the government has elected to do here is to amend the legislation so we can get the reform through more quickly than we otherwise could. I can assure you that we are looking at introducing comprehensive new legislation at a future date after the policy statement on long-term care comes in. At that stage, when we bring in this comprehensive legislation, we can try to have more suitable modern language. We'd like to do it, quite frankly, but I'm a lawyer and I know how difficult it is to go through this process. We felt that it was important that we get the reform stated now in order to raise level of care.

I'd just like to ask you one question with regard to the placement coordination service. I assume you're quite happy with the way it works presently in Guelph.

Mrs Doughty: I didn't really say that, because at the moment—I don't have a lot of experience with that since admissions are handled through the administrator. When we set it up originally, we thought it worked very well and I really don't hear a lot of complaints about it, except that the placement coordinator, under the new legislation, appears to have complete control. We have some questions about that and some concerns.

Mr Wessenger: I'd just like to ask you, do most of your admissions go through the placement coordination or all of them?

Mrs Doughty: They do at the moment, I think. Is that not right?

Mr David Hicks: Up until a few months ago we had been maintaining our waiting list for people who, through experience, had determined that the Elliott is their place of choice. They felt quite informed about the options and so came to us directly. With news of the way the government

was moving, we didn't want those people to be left without any further options should the rules totally change. We've had an excellent relationship with the placement coordination service and people who have gone through there have been referred to us as well.

Now, we've shifted our entire waiting list, which was approaching 100, over to placement. It's working smoothly between placement staff and ourselves; the problem is with the community. A person like Mrs Featherstone, when she first came to the Elliott, had known the Elliott from her involvement in the community. They feel that we're not treating them as openly as they'd like to be because we're saying, "You have to go over there and see placement." "Why?" This is an 85-year-old who's confused. "My mother was at the Elliott. My aunt

has gone to the Elliott. I've been on the Elliott auxiliary. I only want to go to the Elliott. Why can't I just come and get on your waiting list?" That's where there's a confusion, but we're doing the best we can to work it out.

Mr Wessenger: Fine. Thank you very much.

The Chair: I want to thank you all for coming this morning and for your presentation. It was extremely well done.

To the members of the committee, before adjourning could I remind everyone we have a very tight schedule this afternoon. We must begin at 1:30. The bus will be at the hotel at 6:15. I would ask everybody to make every effort to be back here at 1:30. This meeting stands adjourned.

The committee recessed at 1210.

AFTERNOON SITTING

The committee resumed at 1330.

VICTORIAN ORDER OF NURSES, BRANT-NORFOLK-HALDIMAND BRANCH

The Chair: Good afternoon, ladies and gentlemen, as we all scurry in from the cold and grabbing lunch. Let members get their coats and boots off and come back to the table. As they do that, I would just note that it's the standing committee on social development, and we're here to review Bill 101 dealing with long-term care.

Our first witness this afternoon is the Victorian Order of Nurses from Brant-Norfolk-Haldimand, if they would be good enough to come forward, or I should say if she would be good enough to come forward. I'm sure it's quality over quantity.

Welcome to the committee and thank you for coming today. If you would be good enough just to introduce yourself, both for the members and for Hansard, and then please go ahead with your presentation.

Mrs Cathy Chisholm: Thank you, Mr Beer, and good afternoon. It's a pleasure to be here today to make this presentation to the standing committee on social development. I am Cathy Chisholm, the executive director of the Brant-Norfolk-Haldimand branch of the Victorian Order of Nurses.

The Brant-Norfolk-Haldimand branch of the VON began its community service in the city of Brantford with a staff of one nurse in 1907. Demand for services grew and was expanded over the years to include all of Brant county and the counties of Norfolk and Haldimand prior to 1972. Today, the head office of the branch is located at 446 Gray Street in Brantford. There are suboffices in Cayuga, Delhi, Jarvis and Simcoe.

A staff of 130 nurses and 250 homemakers represent a tremendous range of experiential and educational backgrounds. The volunteer board of directors represents a cross-section of the entire branch area, bringing a variety of skills, expertise and community awareness to their governance role, which includes the responsibilities of fiscal management and strategic planning.

Programs currently offered by VON Brant-Norfolk-Haldimand branch include visiting nursing, visiting homemaking, foot care, Alzheimer respite, enterostomal therapy, occupational health, palliative care, early obstetrical discharge, intravenous therapy and placement coordination.

To meet the challenges of the future, the branch is exploring a variety of integrated modes of service delivery. Pilot projects are under development for implementation in the 1993-94 year. In one part of the branch, a team of workers will include registered nurses, registered nursing assistants and levels 1, 2 and 3 home support workers. In another area, the branch is seeking to develop collaborative partnerships with other service provider agencies.

It's from the perspective of a multiservice agency and a major community service provider in the current system that VON Brant-Norfolk-Haldimand branch offers these comments on the proposed legislation, Bill 101. The areas

of concern that I will outline include continued fragmentation of the system, limited empowerment of the consumer, inspection and control versus quality management, allocation of resources and placement coordination.

While I certainly acknowledge that Bill 101 was not intended to be the final piece of legislation in connection with long-term care, and there has been some attempt to pull together some facets of the long-term care system, however, there has been a significant piece of this system that has been ignored thus far and that is, in particular, the community sector. The picture presented is not, at this time, one of a redirected, fully integrated system.

Bill 101 is an incremental improvement in that it starts to standardize legislation for long-term care facilities, but does not replace the separate legislation and does not address chronic care beds. VON believes that because the tone of the amendment is incremental, it can be interpreted as less than comprehensive, and it would be most unfortunate if this happened, since the government's vision of system redirection is much broader.

We have a recommendation that the passage of Bill 101 amendments be delayed until the publication of and public debate on the government's long-term care redirection policy framework, and further, that Bill 101 then be rewritten to include the entire spectrum of long-term care.

With respect to limited empowerment for the consumer, we acknowledge that Bill 101 begins the empowerment process in that it allows for direct funding grants to the physically challenged, it ensures consumer access to key information regarding facility services, care, accommodation and consumer knowledge of the care plan and allows for an appeal process regarding eligibility for service.

We offer further recommendations. We support the incremental improvements and recommend that the changes be expanded to include requirements for residents' counsels in all long-term care facilities. VON recommends that consumers have a choice of whether to receive needed services in a facility or community setting within an envelope of available resources. In short, the consumer has the choice of service location.

VON recommends that if the consumers require, and they or their surrogate decision-makers choose facility care, they have the choice of what facility to enter rather than this decision resting solely with a placement coordinator.

Inspection and control versus quality management: History has demonstrated that control through inspection does not always achieve the desired results, but rather increases inappropriate behaviour through the fear and uncertainty created by the inspection process itself. Inspection does nothing to foster creative and truthful relationships which lead to enhanced service provision. Continuation of the inspection system implies a lack of trust in service providers and/or the belief that the achievement of quality improvement standards is not possible.

The necessity for services provided to improve in line with expressed customer needs is a true hallmark of consumer empowerment. VON believes that other processes exist that provide assurance regarding quality of service, and that these processes should be explored prior to the imposition and/or expansion of the inspection system.

Therefore, we recommend that Bill 101 be rewritten to reflect quality management principles to ensure that the highest standards of care be available for the consumer.

Allocation of resources: Bill 101 appears to ensure the continuation of a centralized funding of extended care beds, given the absence of reference to chronic care beds and the separate funding of them. Although funding of long-term care beds is not addressed in the legislation, from government discussions VON understands that level-of-care funding will be introduced in regulations.

At a time when the government is considering the need for flexible funding and service delivery models for the community sector—for example: capitation, case mix, equity blending with global funding, comprehensive health organizations, multiservice agencies—consideration could also be given to the possibility of multiple-funding options for long-term care facility beds. However, VON agrees that the current funding model of per diem is a disincentive to caring for residents with complex needs and intensive resource requirements.

The new model should also have fiscal incentives for rehabilitation and discharge, since level of payment based on customer acuity can be seen as an incentive to increasing illness. Is there a danger that the facility need to increase revenue will conflict with the true consumer need for minimal facility service?

VON suggests that the development of comprehensive multiservice agencies, by VON and other community agencies funded by capitation, may significantly reduce the bed requirements by providing more comprehensive and potentially cost-effective options in the home.

Prior to expanding facility services, other community-based options should be considered, such as having the funding envelope locally administered to achieve more flexibility. Additionally, utilization of community-based services, such as acute care nursing skills or specialty consultation teams within facilities, should be considered as part of the funding option. As an example, VON nurses trained in infusion therapy could provide such services to long-term care facilities that do not have frequent enough requirements for infusion to make an in-house team cost-effective.

VON would also support a provincial role in long-term care facility planning through the development of provincial standards and requirements for core programs. VON strongly recommends that the government move away from centralized, fragmented funding to district funding authorities—devolution, in other words—with a long-term care envelope that includes community-based, in-home and facility service provision. Only then will we see a significant redirection in long-term care from institutional care to community-based services and the development of flexible, cost-effective services reflecting community need and priorities.

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Placement coordination: VON supports the concept of expanding placement coordination services province-wide as a key component of long-term care redirection. VON

currently administers 10 placement coordination services across the province, so it has a wealth of experience from which to provide feedback and comment.

VON has concerns about the lack of consumer control over location of services in the proposed expanded role of placement coordination, and recommends compelling coordinators to ascertain and provide the consumer's choice of service location. VON has concerns about the continuing lack of clarity and authority between discharge planners in acute care hospitals, admission or placement coordinators currently employed by long-term care facilities and official placement coordination services. The overlap in authority and mandate often results in inequity of access for consumers, and therefore we opt for the recommendation that final authority for decision-making with respect to facility placement rest with the official placement coordination services to ensure equity of access for all consumers.

VON recommends that the devolved long-term care management board would be an ideal place to house the placement coordination service. Since this board would fund all services, it is a logical location for information referral and placement services.

I would like to thank you for this opportunity to come before you today. I would be pleased to respond to any questions that you might have.

The Chair: Thank you very much for your presentation. Certainly, as the committee goes through its hearings, if we didn't know the Victorian Order of Nurses, we certainly know it better as we've made our way around and we're glad that you've come forward.

I just remind members again that we have a very tight schedule this afternoon. I will permit one question from each caucus with one short, sharp supplementary. We will begin the questioning with Mr White.

Mr Hope: No speeches.

Mr White: I'm going to have to work that out—one and a half questions here—because there are so many things in your presentation that are very striking. The issue of consumer choice and a number of other things we've already discussed in some detail. The concern I've had from the beginning is that yes, we're taking on the biggest part of long-term care. The facility-based service is the most expensive part and certainly the part that's been, in the past, most in disjunction. But what you're suggesting is that by taking on facility-based, medically oriented facilities and not addressing first what the needs of people are in the community, we're getting the cart before the horse.

Mrs Chisholm: I don't think that's what I mean to imply. Certainly we don't mean to imply that in fact you are neglecting the community side. All we're saying is that they need to proceed in tandem so that the community as a whole is able to understand how the system fits together. At this point in time, it still appears very disjointed. You have the facilities here and the community sector in another place.

Mr White: Would you like to see, with this legislation or with further legislation or programs, the issue about services that are presently available in the community on a broad-based level—psychological services, social work

services, podiatry etc—some things which are not always generally available at all facilities to be now available under that umbrella organization you were talking about?

Mrs Chisholm: That certainly is one way of providing those services. I think, more basic, in response to your question, would be that the funding base across the province with respect to the facilities needs to be more equitably arranged so that those services can be available. Whether it is through the facility itself that they are available or through some kind of a community agency doesn't really matter as long as those services are available.

Mr White: Onsite.

Mrs Chisholm: Or available to be brought to the site as required.

Mr White: Yes. Thank you very much, Mrs Chisholm.

The Chair: Thank you. The Chair notes a very skilful third question in there.

Mrs Fawcett: Thank you for coming before us today. Certainly, as the Chair mentioned, we have heard from several chapters, but each of you has presented us with maybe a different piece of information. However, one chapter, and I've forgotten which one it was, did mention a problem around the VON going into the community to help a client, and then that client having to go into an institution for a week or two. Certain procedures were being given to the client, and then, once the client went into the institution, there was a problem with the VON going in to continue a service which the institution couldn't do. So there was a slight problem there.

I'm wondering, does that happen often? In your presentation, I noted that you mentioned being able to go into an institution to deliver services, and possibly if we could coordinate this in some way, or if it was part of the regulations, then maybe this would alleviate a lot of problems all around.

Mrs Chisholm: Yes, I certainly think it would. It has not been a problem particularly in my branch, although we have had requests from institutions or facilities to provide instruction for staff in certain procedures. There's no physical reason why a VON could not go into the institution; the block at this point in time appears to be the legislation with respect to payment. If the client or the family were willing to pay independently for a VON visit so that service could be provided in the institution, that is possible, but a lot of people don't have that kind of resource.

Mrs Fawcett: Right. Then, just very briefly, we haven't had much on palliative care, and that is of particular concern now, especially around AIDS patients. I'm just wondering, are there any recommendations that you might have so that we get that part of health care done properly and possibly have less consternation among all people, and get it right the first time when we're writing the legislation or the regulations? The minister did mention it briefly, but there was nothing really to give us anything to hang on to.

Mrs Chisholm: Yes, and the funding that has been announced, I think we would all certainly acknowledge, is not adequate to provide a blanket of palliative care services across the province. It's a beginning. It needs to

be expanded over time. But there is the opportunity now, with funding to be available for some part of palliative care services, to probably do a little bit of pilot testing with the various programs that are able to be achieved with the funding available, so that when more dollars are available further down the road, we will then be able to do it right the first time.

Mrs Fawcett: Thank you.

Mr Jim Wilson (Simcoe West): Thank you very much for your presentation. A number of points that you raise, VON has raised. We're very sympathetic, particularly with regard to your concerns with the consumer choice, inspection, the level-of-care funding and the per diem system—"devolution," as you put it—and the placement coordination service as envisioned in the bill.

I want to ask you, though, a general question. You had a phrase near the beginning of your presentation where you stated that Bill 101 perhaps perpetuates a "continued fragmentation" of the current system, then went on to talk about the fact that we're doing this in a policy void, that when it comes to it, we don't really know what's going to happen to chronic care in this province because we haven't got the chronic care role study, and yet we're going ahead with this bill. Then you asked the committee to consider a delay of the legislation until there's a public debate.

I want to just give you an opportunity to sort of expand on what you meant by "fragmentation" and why the need for delay.

Mrs Chisholm: When I speak about fragmentation, what I mean is that all we're seeing at this time is one piece. We know there are more pieces to come, but those pieces continually seem to be delayed. I'm referring particularly to the policy framework with respect to long-term care, which will probably give us the overview so that we can see where the pieces all fit. Right now all we have is one piece that appears to deal specifically with the institutional side. There's great need for change across the whole system, so I guess maybe it's a little bit of impatience in that we'd like to see it all and see how it fits together so that then, as we are participating in the planning forums in our community, we will be able to make better decisions, when we can see what the whole picture is to look like.

Mr Jim Wilson: I'd certainly agree with you there. We're trying to press the government to not go ahead with the legislation until it makes a further announcement so we can see what the whole plan is. I appreciate your good efforts in that regard too.

The Chair: Thank you very much for coming before the committee this afternoon.

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COUNTY OF LAMBTON HEALTH AND SOCIAL SERVICES COMMITTEE

The Chair: Could I call our next presenters, the corporation of the county of Lambton, senior services department, if you would be good enough to come forward. I'm reminded as you get settled that the last time I saw you was a very hot August day, not really like today at all. I think I prefer the hot August day. Thank you very much

for coming over from the county. Would you be good enough to introduce the members of your group, and then please go ahead with the presentation.

Mr Ken Evans: Mr Chairman and members of the standing committee on social development, let me introduce myself and my colleagues for this presentation. My name is Ken Evans, chairman of the health and social services committee for the county of Lambton, and mayor of Arkona; Mr Jim Foubister, vice-chairman of health and social services for the county of Lambton, ward I councillor of Lambton county council and alderman for the city of Sarnia; Mr Doug Hutton, director of senior services for the county of Lambton; Mrs Janice Boomer, administrator of North Lambton Rest Home, Forest, and Lambton Twilight Haven, Petrolia; Miss Victoria Lucas, acting administrator, Marshall Gowland Manor, Sarnia; Miss Virginia Cates, coordinator of outreach; and Miss Marie MacLaughlin, administration coordinator.

Firstly, we'd like to take this opportunity to thank the committee for allowing the county of Lambton to make a presentation and express our concerns with respect to Bill 101. We in Lambton county certainly recognize that reforming the health sector in long-term care is overdue and have very strong feelings on this issue. The care of our elderly is second to none in Ontario. We in Lambton county have recognized that care costs money and have striven to maximize those scarce resources. We have a strong history, as do most counties in Ontario, evolving from the British workhouse to the original house of refuge, which was initiated in Lambton in 1919, with Lambton Twilight Haven opening in 1956, North Lambton Rest Home in 1970 and Marshall Gowland Manor in 1968.

Mr Foubister will be assisting me in presenting the brief. We have additional copies available and would try to answer any questions you might have at the conclusion.

Mr Jim Foubister: Let me begin by applauding the government for recognizing and acting on the need for long-term care reform. We feel it is crucial to retain the inherent good qualities of our non-profit facilities by affirming the county of Lambton's full support for the main principles driving redirection, which are the primacy of the individual and his or her right to a life of dignity, security and self-determination; the promotion of racial equality and respect for cultural and regional diversity; the importance of the family and community; and equal access to seniors' services.

We believe the county of Lambton is the proper body to be responsible for the delivery of both communitybased and institutional long-term care services for seniors in our area, in partnership with a local advisory committee and ministry support that provides clear leadership and performance standards.

We have brought with us copies of our presentation for your future reference and we hope to answer any questions that you may have.

We believe it is important that your committee know something of the history of the county of Lambton's long-term care programs and services. In the mid-1980s, a consultant's study was done for the county that recommended the sale of one of our homes for the aged. When the results of that study were made public, council was somewhat surprised at the depth of feeling among county taxpayers that ownership and operation of that home for the aged remain with the county of Lambton. The sale did not take place, and the home in question has subsequently had a \$1.6-million addition.

That event may have been the turning point that stimulated this council into being one of the most innovative, interested and capable in Ontario on seniors' issues and seniors' care. Consequently, we will be opening the new 128-bed Lambton Twilight Haven in Petrolia later this spring. This is a joint venture with the province, at an estimated cost of \$16.4 million.

As we sit here today, we cannot emphasize too much the importance of the positive relationship between our council and the seniors of the county of Lambton. They have come to depend on us to know their needs related to high-quality programs and services.

Under the topic of governance and accountability, our major concerns with the draft legislation are:

- That a resident must be accepted on the advice of some person or agency external to the operation of the institution.
- The mandated requirement that a municipality pay for the operation and maintenance of a home for the aged without the ability to make policy decisions with respect to the institution's management.
- An assumption that inspections and regulations will bring compliance with generally accepted standards of performance rather than those that are self-directed through programs such as quality assurance and accreditation.
- Too much stress on regulations that have not been revealed and that are much more easily changed than is the act.

One of the gravest concerns we have is that the direction of the proposed changes is towards greater municipal responsibility to provide care and payment, coupled with a reduced role in decision-making. As you well know, it is only the elected local officials who are accountable to the public they serve.

Along with other groups, the county of Lambton opposes the inspection powers being promoted for the following reasons:

- They promote a feeling of opposition rather than one of partnership.
- They tend to ignore the current positive role of the committee of health and social services of the county of Lambton.
- There is no assurance that the inspector will have skills and abilities that match those of people who are working locally and within the institutions.
- No funds have been identified to carry out mandated structural improvements or corrections.
- There may be no provision for learning exactly the nature of future problems or disputes.
- They will almost certainly create an atmosphere of tension, suspicion and loss of county of Lambton control.

We believe that the proposal to add a mandatory placement function as the "gatekeeper" to the system adds an unnecessary level of bureaucracy to a system that now works, and works well.

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We are frankly distressed at a system where such a person or agency assumes none of the responsibility for placement problems. It all resides with the home for the aged, which had nothing to do with the placement in the first place.

With regard to enforcement bureaucracy, we believe that, given the number and extent of legislation now governing the operations of homes for the aged, the proposal to add compliance and enforcement units will result in unnecessary levels of bureaucracy. Furthermore, such units, based at Queen's Park, are bound to introduce an air of concern and worry about their potential for mistrust and unreasonable intervention. The municipal homes for the aged now believe that we operate in a constructive and healthy partner relationship with the province of Ontario, one that is now in danger of being degraded.

The county of Lambton believes that we should be the governing body with an advisory board for community input. We would suggest that you consider a closer link between the government and the accreditation process, providing a constructive and educational system that works effectively now; increased support of internal quality assurance programs; and increased support of risk management programs.

I would now ask our chairman, Ken Evans, to lead you through additional parts of the presentation, and I thank you.

Mr Evans: Consumer choice: Under this topic, the major concerns with the draft legislation are that we would see a centralized bureaucratic control and loss of fundraising capability. There is grave concern that the consumer has no choice in the placement exercise, nor in the purchase of goods and services judged appropriate by himself or herself. No consideration has been given to the importance of choice for the seniors with respect to the rural or urban setting of a home for the aged, or cultural setting alternatives.

While an appeals process has been established but is still largely undefined, the process is likely to appear intimidating and daunting to the average senior. The appeals process will inevitably add considerable time, cost and stress to the overall effort to place a senior and family that may be aggravated by the wait for a decision or, more importantly, that may never be placed because the "window of opportunity" may go past while awaiting an appeals decision.

We are concerned that the present placement coordination service is not capable of knowing the nuances of service delivery and planning that the home's own administration does.

At present, our county homes for the aged effectively work with families to redress social and physical problems of inappropriate placement. The draft legislation does not identify an appeals process that can take their place.

Through the draft legislation, it appears that the residents of the provincial institutions will not be consulted about important and fundamental changes to the way they will be cared for. For example, the implementation of the proposed copayment will probably cause worrisome adjustments for many residents and families, yet there are no plans to prepare them for this change.

Our delegation recommends that the government ensure consumer choice be given a much higher profile through better notification to residents and families of the legislative process through resident councils in the homes for the aged; consultation with families and seniors about options with respect to placement mechanisms; and legislation that gives seniors, their families and advisers a more proactive role in choosing the place of residence and treatment modalities.

Mr Foubister: Thank you, Ken. We applaud the government's pledge of \$206 million annually to the support of long-term care facilities. The county of Lambton, as a member organization, supports the Ontario Association of Non-Profit Homes and Services for Seniors' position that inadequate calculations have been made to establish funding requirements for the proposed system.

Under this topic, the major concerns with the draft legislation are:

- The county of Lambton is firmly opposed to not include a resident's assets.
- Residents have not been informed or consulted on copayment schemes and the changes that will result;
- Mandated levels of care, and hence operational costs, are increasing with each passing day, but provincial support is not keeping pace;
- Educational needs of staff, and hence training costs, are increasing with heavier care levels;
- Chronic are facilities are better funded than homes for the aged, yet the care level in many instances are exactly the same;
- Bill 101 identifies capital funding for nursing homes but not homes for the aged;
- No funding provision has been made for mandatory programs such as modified work, workers' compensation and union contract settlements, which therefore must be subtracted from resident care;
- The \$37-per-day copayment proposal is fundamentally flawed with respect to the estimation of how many of the current residents will be able to make the payment; and the loss of revenue from those now in preferred accommodation.

Historically, budgets have been prepared locally in the home for the aged according to the needs and traditions that are found therein. The county system of government has been very good at serving local need.

This delegation recommends that:

- Local controls be retained with respect to both copayment schemes and fund-raising;
- Chronic care be addressed and included in Bill 101 to help reduce the fragmentation of long-term care services;
- The shift in emphasis be taken from the "funds available" approach to a "consumer needs" approach.

Under the topic of quality of care, the major concerns we have with the draft legislation are:

- No consultative process with residents' councils in long-term care facilities;
- A rigid approach that disallows preferred accommodation with its incentives for consumer choice and institutional upgrading;
- The primacy of the individual has been lost in this draft legislation exercise:
- The planned constraints of the legislation are so great that quality of life must suffer.

We recommend that the quality of life of each Ontario senior, through a holistic consideration of the individual's needs, be reinstated as the main focus for drafting new legislation.

Finally, we believe, most emphatically, that the county of Lambton is the most appropriate body to govern the delivery of high-quality, long-term care to its seniors. This body has historically provided responsible control over budgeting and operations as a result of its direct responsibility to its local citizens. County councillors, as elected representatives, are ultimately responsible to the taxpayers, and as you all know, we must raise this money by literally putting our hands in the pockets of the home owners of Lambton county. We must therefore have the ability to govern care and service delivery at the local level. Centralizing these controls at Queen's Park, with a larger bureaucracy and its attendant lengthy and complicated appeals process, is wrong.

I assure you that we do not have all the answers, but we have a very long history of a partnership with senior government in providing the seniors of Lambton county with a premium health care service.

We wish to thank you, Mr Chairman, and the members of the committee for your diligent consideration. We're sure that you'll give these important matters, that will have a profound impact on the elderly in the province of Ontario for many years to come, your utmost attention. We wish you very well in your ongoing deliberations. Thank you very much.

1410

The Chair: Thank you very much for a very thorough brief. I may be wrong, but I think it's the first county brief we've had where you've really addressed a lot of those issues, or has there been another?

 \boldsymbol{Mr} \boldsymbol{Jim} $\boldsymbol{Wilson:}$ I think this is the second one; I am not sure.

The Chair: Second? Okay. In any event, we thank you for that. We'll begin the questions with Northumberland county and Ms Fawcett.

Mrs Fawcett: Thank you very much, and I do appreciate this perspective from county councillors, because I did spend a little time on county council and I believe in a strong county. Certainly, this brief shows that you have a lot of expertise. As you said, you may not know all the answers, but I think maybe you know more of them than would be known at Queen's Park. You would know what the needs of your community would be certainly better than maybe some of the people at Queen's Park.

However, right at the beginning, I compliment you on many of your suggestions in a lot of the areas that people have continually brought up. I think you really have done an excellent job.

But back on page 2, under "Municipality Responsibility," I was intrigued by what you said there, "That the direction of the proposed changes is towards greater municipal responsibility to provide care and payment coupled with a reduced role in decision-making." I just wonder if you would like to broaden that a little bit, as to how you see that happening under Bill 101 that is different, let's say, than what you have shown us you can provide.

Mr Doug Hutton: I think what we're trying to express is that we, as a municipal government, and the deliverers of services and seniors in institutions are faced with the challenges of Bill 101. We're given certain requirements, they're mandated, then we're expected to pay our fair share. I think there was an expectation that we're either buying into this system or we're not going to be in this system. I think the county has historically been in this system and wants to be part of the system. So if we're going to have a say in the system, if we're going to pay, we want to have a say.

You were adding all these mandated requirements, levels of care, that will be addressed by the inspection process. There's got be a funding arrangement made corresponding to these. We also feel that if we're going to make decisions in respect to the delivery of services—and we feel that we may put a higher level of care and a higher level of service that maybe is required—we should ultimately help make the policies on that. We shouldn't stick to just what the base standard is: "It's good enough for everyone else." Maybe in Lambton county, they expect more because they were the folks who made that county.

Mrs Fawcett: Or maybe you are more rural than, let's say, downtown Toronto and so there are very sincere differences.

I would assume that you would want to be the placement coordinator. You would take on that role because you already are doing that, obviously, pretty well for the county, and you see yourselves as being able to carry out that role very well.

Mr Evans: That's right.

Mr Jim Wilson: Thank you very much for your presentation. As Health critic for my party and on behalf of my caucus, I want to tell you that I think you're right on in a number of the points you raised. I also represent an area in Simcoe county, and I'll tell you our county administrators and the good people on our social services committee are very worried about this legislation.

I'm allowed one question but it has three parts. You began by saying that you very much support the four principles behind the Redirection of Long-Term Care. But like many other groups, I gather from the tone of your presentation that you agree that the principles are laudable and, as laudable as they may be, don't appear to be reflected in the actual legislation, because you mention consumer choice, facility choice and the idea that we're to have levels-of-care funding, but you won't be necessarily getting the

funding so that you can implement levels-of-care funding. You will be required to admit older and sicker residents, and there's no guarantee that the funding will follow.

I want to ask you two things. One is that I want you to expand, because I think it's an important point to drive home, again how you feel this bill may undermine the authority of your health and social services committee in the county itself. In answering that question, I want you to tell us how much money out of the property tax base the county actually commits to its homes and how many homes you're running.

Secondly, just to touch on what appears to be an adversarial inspection system that's being set up, one point that hasn't been raised that was raised by one of my county homes was that what may appear a simple thing to legislators may be something very wearisome to residents. That is, when you post the results of an inspection, there may be things posted on the bulletin board at home that people will take out of context and that may unnecessarily worry residents; they may not understand some of the things. If there are eight or nine things listed on the board, they may take them out of context and sort of blow them up out of proportion. So with all those comments, I want to give you an opportunity to say a few words about those concerns.

Mr Hutton: With respect to your comment on how many homes we run, we have three homes for the aged in Lambton county, in the various geographical sections of the county, to address all the needs of those residents. They reflect both an urban and a rural setting. Certainly, to address the comments of your colleague, we don't have the problems that they have in the large urban area of Toronto, where you have the ethnic minorities but you have a large workforce that can provide the expertise.

We have no transportation in the county like they have in the large urban centre. We can't draw on those highly skilled technical people who can offer us their professionalism there.

We have a different makeup of whom we have to deal with. This is their home. They've been in the county for a long time and they don't want to get transported off to a large urban centre when they've always been in the country.

Last year we capitalized, through the funding process that we normally run, approximately \$1.5 million for the 1993 operating budget, with the county committed to this. But over the last two years we have committed over \$9 million in the homes for the aged through a new building process which is a 50-50 partnership, as well as the additions, and we're looking forward to renovating the other home for the aged to bring it up to standard.

With respect to the posting and the inspection panels, yes, I worked in the for-profit sector of the nursing homes section and we did enjoy that privilege, I guess, of having the inspectors come into our home. It was threatening to the residents. "What, are they going to close the kitchen down if you don't fix it in three days?" Certainly they would leave us with, "It's on the wall and these are the problems."

Through the system we currently have, we work within a partnership with the province through the local area offices, and it has been a cooperative relationship. We have problems at the level of care, of nurses. We work

together to meet those needs. It wasn't, "Thou shall put four nurses on." In the for-profit sector—certainly they have been underfunded in the past, and we don't dispute that at all, but the homes for the aged have historically said that we're fat cats. I think we're not fat cats. What we've done is that our community has recognized that we want to have better than the standard, and we funded it to be like that. So the inspection process is very intimidating. It's intimidating for the residents too because they don't know what's happening. It's very confrontational.

With the funding mechanism we currently have in place, county councillors and county council recognize the needs. They can prioritize those needs and they can talk together and identify needs: "Yes, we're having heavier care. Heavier care costs money. Yes, we need more nurses. Yes, we need more staff. Yes, we need this and we can work together to improve that." County council then makes a commitment of dollars to increase the system. Certainly, the ministry provides us with X number of dollars on the operational side of it, but then we can add those additional dollars to bring in the in-house pastor to look after the spiritual needs of the resident. Maybe under another system, we'd have to hope for the volunteer sector to come in.

Mr Jim Wilson: Very good points. Thank you very much.

Mr Wessenger: Thank you very much for your presentation. I note your interest in wanting to govern the care and service delivery at the local level. If you might elaborate on that, does that mean you want to manage both the institutional long-term care and the community long-term care? Would that be your intent?

Mr Hutton: No, not totally. **Mr Hope:** Well, why not?

Mr Hutton: If you're open to that suggestion, I think what they're suggesting and they're suggesting very strongly is that an elected, accountable politician goes to the ballot box and is elected to perform, to look after the taxpayers' dollars. Certainly we recognize that there are other advisory groups out there, but they can't work in isolation of what the taxpayers want, with their own agendas. We're suggesting that there should be advisory groups out there, but accountable to a locally elected body. The one best suited is the local county council, which is elected by the will of the majority. It also represents the various geographical areas of the county. It also reflects what the residents of that county would like to see, and if they don't like it, they can put them out. And a special-interest group are just appointed.

1420

Mr Wessenger: Could I just follow that up? Do you have any for-profit nursing homes in your area?

Mr Hutton: Yes.

Mr Wessenger: So if you took over the placement coordination function, you'd be making adequate—

Mr Hutton: I don't think we're suggesting that we take over the placement. We're looking at, when the envelopes of dollars come into the area, having that body, the

county council, then distribute those to the needy. But there would still be a placement coordination; there would be all those other things.

Mr Wessenger: Okay, could I just follow up? What you would like to see with the envelope of funding that comes into your area? You'd like to make the decisions on the allocation of that funding envelope?

Mr Hutton: Yes.

Mr Wessenger: You would, I will just follow up with one other question which I don't think you answered for Mr Wilson, although he asked it. I wanted to ask the same question. You indicated that there are decisions you now make that you're afraid you will lose the ability to make in the future. Could you sort of indicate specifically what those decisions are that you now make which you are fearful of losing in the future?

Mr Hutton: Level of care, for one. We're the catchment area for the whole county for Alzheimer's, so if someone is affected with Alzheimer's, our new unit is specifically addressing the issue of the Alzheimer's resident on a staged program method so you don't have them all thrown into one area. We have day programs, and we feel that this is one of our top priorities. We feel we might lose that.

Mr Wessenger: Fine. Thank you very much.

The Chair: Did anyone have any other comment they wished to make in answer to that? No? Thank you very much for coming, and we wish you all the best with the new home in Petrolia.

Mrs Caplan: Thanks a lot.

Mr Foubister: Thank you, Mr Chair and members of the committee.

VISION NURSING HOME

The Chair: I would ask our next presenter, from Vision Nursing Home, Sarnia, to come forward, please. Welcome to the committee. Have some London water—it's cold—and once you're settled, if you would be kind enough to introduce yourself for the committee members and for Hansard and then please go ahead.

Mr Bernard Bax: Thank you, Mr Chairman and members of the committee. I appreciate the opportunity to address the committee. I might as well admit right off, I'm scared to death.

Mrs Caplan: The only person who bites here is the parliamentary assistant.

Mr Bax: All right. Well, I won't look at him.

Mr Hope: Oh, we have differences of opinion about this one.

Mr Wessenger: That's right. The Chair and I are both that way.

Mrs Cunningham: We just bite each other.

Mr Bax: Well, I do appreciate the opportunity to come and talk to you. My comments will be rather pragmatic, I suggest, but after long thinking about it, I feel it is important to let you know at least my particular views on Bill 101.

I am aware of and have read the official response of the Ontario Nursing Home Association to Bill 101, and I want you to know I basically support their response. I would, however, like to reiterate some points and to add my own perspective to some of the points raised in their brief. I think you all have that brief.

The first thing is timing. I'm delighted the government is moving ahead with long-term care reform. From my perspective, it's long overdue. I am extremely disappointed, though, that the target implementation date of January 1, 1993, has not been met. From my perspective, it only means that the inequities will continue longer and, from my perspective, become worse, as it appears for the private nursing home sector that there will be no economic increase, which has usually been given January 1. We now understand that will not happen until long-term care reform is implemented, and hence my encouragement to make it timely, because for us the cost increases don't stop.

A 1989 lawsuit was initiated by the ONHA, and the subsequent judge's comment that the present system is illogical and unfair is, I think, true. I think we all agree that it's true. This was in 1990, and I'm encouraging the government to not delay the implementation of long-term care any longer. In my opinion, it would only make a bad situation worse by not providing economic adjustment.

As to some specific concerns that I have regarding the legislation, first of all, I'd like to address the appeal process. I think fundamental to our system of justice is the right to appeal. I cannot imagine removal of the right to appeal in the criminal justice system. For obvious reasons, mistakes of one sort or another are made and there is a need to prevent potential abuse of power by a person. The inclusion of the right to appeal within Bill 101 is critical from two perspectives—and I believe in the right of consumers to appeal but also the right of facilities to appeal. Neither is there right now in Bill 101.

First, the right of consumers to appeal: Applicants' choice relative to ethnic, linguistic, geographic and religious preferences must be preserved. Arbitrary decisions that are potentially possible by placement coordinators must be open to appeal and, I feel, quick appeal equally. The reasons are obvious, I think, if you place yourself in the shoes of a person who requires placement. If a person is of a particular ethnic background and there are a number of choices in your area, you would certainly want the right for that person to choose where his culture and his history can be preserved and where he can enjoy that particular aspect of his life. If a placement coordinator decides to not respect that, certainly that person should have a right to appeal to someone regarding that decision.

The right of facilities to appeal: In a number of areas, we are anticipating moving from an insurance to a contractual model in long-term care. Because it is contractual, negotiation is equally part of the process. Facilities may be treated differently depending on the person that a particular facility negotiates with. This would, for me, not make the standard of care equal throughout and could provide disparity in particular areas. I think that needs to be addressed.

The other area is that governments change policy, governments put in new programming, and it could be the

case equally where that is not recognized in contract negotiation. That must be there. I guess, in brief, there must be government accountability in that if policies or legislation are passed, they must follow through with the appropriate resources to implement that particular aspect. It's my feeling that if we go to the contractual model, discrepancies could begin to appear.

I think facilities must equally be able to appeal possible placement recommendations. For obvious reasons, there are differences in facilities. If they can't provide the care needs—and it could also be the practical thing that we have wards and we have semi-private rooms and, as in all of life, we are not all compatible. It is equally that reality in nursing homes, that two people don't get along, that one is cognitive and noisy and another placement may come in who appreciates the quiet. It's very disruptive, and if you have visited a nursing home yourself, you should be well aware of that. That can happen, and the legislation must allow for the homes to be able to appeal to make sure the best possible placement is made.

The third area where homes must be able to appeal is that Bill 101 has sanctions listed, and this gives, in my viewpoint, enormous power to government. I feel sanctions should only be used as a last resort. Above all, facilities must have the right to appeal bill sanctions.

In summary, on the appeal part of Bill 101, I think in all cases, though, that the appeal process must be very accessible. It must be timely and it must be efficient and if it's not—again, I ask you to place yourself placing one of your parents and he or she is inappropriately placed. It's really not much good to argue about that three months later or to appeal if your mother has been placed inappropriately and she's unhappy. It could be done at the local level with some kind of an appeal further down, but it must be timely and it must be efficient and it must be highly accessible. Bill 101, I feel, has an obligation to provide for that.

1430

The second area that I would like to just touch on is the resident care needs. The bill is being introduced, from my perspective, in almost a total vacuum. I really don't know a lot at this particular point, and for me as an administrator of a nursing home that's scary. I've written here that there's no commitment that funding is equal to level plus the adequate services. To me, it's extremely important that when that bill is introduced, we know there is a balance between dollars and what is being legislated. If not, I think we could be headed for trouble.

All long-term care institutions in Ontario were reviewed last fall. All our residents were assessed—called the case mix index. We were promised the results of it in December, in January and now it's February and we still don't know what the case mix index is.

The scary part for me is that the case mix index is being delayed and that we're only going to distribute dollars, not really listen to what the case mix index is saying. All we're going to do is distribute the dollars from facility A to facility B, but the total dollars are not going to be there. In other words, it's not truly an assessment based on need, to provide for the needs that are really there.

The third area I'd like to just touch on is the placement coordination service. The details of how the placement coordinators function are entirely missing. It's my feeling that the existing resources in the placement coordination facilities should be used. They're doing a good job.

The item that probably bothers me a little bit is that their main responsibility is to determine eligibility. Again, from my perspective, eligibility must be the same basis as that used for the case mix index. Then homes will know exactly the type of placement they are receiving. Not doing it that way is really not knowing what the needs are of that particular resident who is coming into the home.

I think it's important that you compare apples to apples. If you're going to determine eligibility, we should all talk the same language, and that part of it should be part of the placement coordinations job that we know, and they can fax or they can tell us about the person we're going to receive. It's not doing any good to tell us after the placement is made, because it could again lead to inappropriate placement.

Placement coordination. I think must also determine if there is the necessity for substitute decision-makers. It becomes extremely important that this be done at the time they enter the system, if there's a responsible party required for them to act on their behalf, as it's now under the Nursing Homes Act—that this be addressed—and from my perspective, also establish the applicant's ability to pay the new consyment. I believe it should be equally part of their function and part of their work to determine their ability to pay and put into necessary paperwork. I understand it will increase substantially, but there's still not a defined or communicative process of how exactly that's going to work if the elderly can't afford their particular resident copayment. It doesn't do any good, I feel, to do that after people have been placed; it should be done ahead of time. I believe Bill 101 in the legislation should also address that.

Compliance consultation is the next area I'd just like to briefly comment on. Maintain the existing compliance program. The enforced approach: Type X theory went out long ago. It doesn't work. Cooperative effort, cooperative work together really makes more sense, and in my viewpoint, the present system works. It has a complaint appeal system whereby residents and families can appeal directly to the Minister of Health or to local offices, and investigations are conducted expediently and everything else. I believe that the enforced approach, as I envision it out of Bill 101, will just lead to coming together—I can even visualize lawsuits or whatever else may occur where discrepancies occur in interpretation. We've gone to a lot of effort to put the present compliance system into place in the last two or three years. Continue to use it.

Comments about quality assurance and risk management: I think "quality assurance" is probably the wrong terminology to use within BIll 101. I think we have to, as we're doing totally in health care, look at total quality management, continuous quality improvement terminology. To take a look at a cooperative effort again, how we're doing things, I think is extremely important. I would equally caution that I'm seeing that there are too many

dollars chasing paper. It does nothing for the care. I'm increasingly concerned that we're so concerned about all these documentary requirements, which I envision more under your possibilities under the new compliance review, that we virtually document and have the people document whether people dress and whether they go to the washroom and whether they have a bath or whatever. It's all costs, but it doesn't really provide a lot of direct, hands-on care. I think you should really think about that aspect.

In conclusion I would also strongly recommend that the committee, before it recommends changes to Bill 101, should also be fully briefed on the four funding envelopes. As difficult as it is for me to come today to speak to you about Bill 101, I don't know what the rest of the package is going to be. I think for you to protect the residents and people in Ontario and yourselves, it's extremely important that you know what the funding envelopes are going to be for nursing, quality of life, accommodation; and the fourth possible envelope, which is the other, whatever that's going to be; and equally, that the government should really discuss these four envelopes with both the Ontario Nursing Home Association executives and the Ontario Association of Non-Profit Homes and Service for Seniors before these are released to all the long-term care facilities. The changes we are making, which are good, are wide and far-reaching, and my concern is that if they're not done properly, they're going to lead to a lot more difficulties and a lot of heartache for the residents of Ontario, and I just think they're a good thing to do.

I think the essence of what I'm really trying to say today too is, don't leave too many issues to be defined by the regulations; I think it's dangerous. I think the time to deal with some of these important concepts is in the legislation, not in the regulations, in order to prevent, again, the drafting of regulations that really are difficult to change once they are there and miss the intent of the legislation that's there.

Finally, the bill holds the facilities accountable for providing for all residents' needs without ensuring that funding will be provided to make this possible. If anything, I'm most uncomfortable, as a citizen of Ontario, and that we stop this, that we not say what we're going to do and not provide the means to do it. To me, it's worse to do that than the other way, to pretend we're going to do something and not provide the funds.

1440

Maybe Bill 101 is a good place for the government to start to take that seriously. If I read my news and if I listen to what we're saying about government deficits in general, I think it's equally important that the regulations truly provide what they say and that we provide the resources to do it.

Bill 101 with its amendments must be introduced, I believe, as soon as possible.

I thank you for the opportunity to share my views with you today, and I'll only allow half a question.

The Chair: Well put. Certainly the points you've raised throughout your presentation are important ones. We're glad you came and we hope whatever trepidation

you may have had has waxed. Now we'll have perhaps three or four half-questions, and we'll begin with Mr Wilson.

Mr Jim Wilson: Thank you, Mr Bax. I just want to reiterate what the Chair has said, that there's really no need to be nervous, unless you consider that this government's going to try and drive private operators out of business.

There are three indications that lead us to believe that. One is that the government did do a study, which it won't release, on what the cost would be to buy out your nursing homes. It spent \$200 million in day care not to create any new spaces or new subsidies, where the problem is, but simply to drive out the private day care operators. We know, from indications from the Ministry of Health, that they want to buy out private ambulance operators. They just haven't figured out where the hell to get the money from. So there's good reason out there to worry. I just wonder if some of your trepidation isn't that they've got you in a classic catch-22.

You need the bill to go forward because you need the economic adjustment, but at the same time, it may threaten the long-term viability of the commercial sector. I'll give you an opportunity to comment on that.

Mr Bax: Sure, it's of concern, but I hope that the government will be practical enough to simply say what the private sector is doing and how good a job it's doing. I'm sorry; we don't get any type of handout from our municipality for running it—and I would challenge all of you to come and visit—and the care that we're providing to do it. I trust that will be the overriding factor in that; I really do.

The Chair: Where is your—Mr Bax: In Sarnia, Ontario.

The Chair: In Sarnia. Ms Cunningham puts a supplementary.

Mrs Cunningham: I am interested in one of your comments because it's of great concern to me within most public institutions, and that is growing size of bureaucracy. You mentioned that, in your view, there are too many dollars put into paperwork and not enough into what I would call the front-line workers.

Mr Bax: Yes.

Mrs Cunningham: There's an opportunity for at least four of the government members to listen to this in your response. If we had to do this all over again, where do you see the big dollars? Are they within the nursing homes themselves, are they within the levels of government, are they within the municipality or is it a combination? Just tell us how you feel about it.

Mr Bax: Oh, I think it's a combination. I think if we, for example, have the universal accreditation process—but the need to really document on paper everything from A to Z and to have proof that we do all these things is not really needed in many homes. They serve no purpose except for some kind of person to really come in and check that certain things have been done.

I really wasn't prepared to respond to that in detail. Given the time, I could certainly take a look at a number of areas where in-services—you know, the resources that are

provided for that versus nurses doing it on-care—our directors and nurses are no longer on-care nurses; they're strictly paper pushers, one way or another, to satisfy a whole host of regulations and government requirements there.

Mrs Cunningham: Can I just have a 30-second comment there?

The Chair: You have 15 seconds.

Mrs Cunningham: Mr Bax, I visited many of the services here in London. It happens to be my riding, and the county of Middlesex too, I should add, only because they're not represented. The point I'm trying to make is that what you're saying is not new. I find it amazing. I know you're disgusted. That's too bad. But I'll tell you right now, it's amazing that governments get away with it, and sooner or later somebody is going to demand accountability, because I've watched it grow in the five years I've been at Queen's Park, and this bill will only make it bigger. It's protecting bureaucracies and not people.

Mr Bax: Yes.

Mrs Cunningham: I feel very strongly about it and I hope the government is listening. It's also a smokescreen to the real issue, and that's the funding. It's not new. I was elected. I found out what was going on in the sector. It took me about three or four weeks. I'm sure these members got the same thing from their own communities. I think we spend far too much time in legislation that's put forth in draft form such as this, with no answers. I'm here today to listen, of course, but I'm also here to tell the government that we spend far too much time on issues that really don't matter. The funding could be dealt with separately, but it's a wonderful time-user-upper.

Thank you very much for being here today. By the way, you should do this more often.

Mr Jim Wilson: And do it more.

Mrs Cunningham: And put those numbers together.

Mr Wessenger: Thank you very much for your presentation. I'm not going to be too difficult because I'm going to make a few comments and then ask you a question.

First of all, I'd like to advise you that no decision has been made with respect to the matter of an economic adjustment for this year, so that's still up for a decision.

The second question is, I note your concern about getting this legislation through as quickly as possible so the level-of-care funding is introduced. I certainly share that desire with you. I can assure you that the government has the same sense of priority in that regard.

What my question has to do with is that you're concerned about being demanded to provide more than you're going to be paid for in the way of service provision. As I understand the way the system is going to work, the level of care is going to be determined for your institution as a whole and sort of as a general level. Then there will be specified funding levels for nursing and personal care, for instance. The money that you will be allotted for that, you'll have to spend on that, of course—you can't spend it in other areas—but you'll not be expected to spend more money than the amount that is allotted for that particular concern. So I was just wondering, what is your concern that you'd

be required to do more than the funding would be available for? I'd just like some clarification.

Mr Bax: Very easy: Come and visit and watch one registered nurse's aide push two residents down the hall to the dining room. In other words, the present system makes no allowance, really, for what the needs are and the resources that we are provided. What we're scared of is really exactly that. We're just going to chase it around. We've done it to simply say, "Those are the needs," but have you really done a time study to simply say, yes, we expect one of our staff to be able to push one resident down to the dining room comfortably in a wheelchair or geri chair, rather than having two of them? So I'm greatly concerned that if the case mix index hasn't truly taken into account the time studies or whatever it is, the needs that are provided. we're just going to again be allocated a certain amount of money with an arbitrary labour pool to do the services that were there.

Mr Wessenger: But it's going to be based on a levelof-care funding, which it isn't now. You just get a flat per diem, no matter what the care that's required. There are levels from A to G, and I understand there will be 5.3 times as much money for a resident at the G level as there is at the A level.

Mr Bax: I need to see that in the envelope and I need to see—the only way I can tell is, I know what I have now. Tell me what my case mix index is and tell me what I'm allocated for nursing; tell me what I'm allocated and I'll tell you exactly where it's at. But I can't really do that until you define for us what these case mix indexes are and the amount of dollars that go with them. I have no way of measuring whether I'm going to be better off providing resources to take care of needs or whether in fact I'm going to be even worse off. So despite the fact that you're right, there are going to be these six levels, what does that mean to me?

Mr Wessenger: There's also \$200 million more, which will provide another 5,000 jobs in the institutional sector as a result of this additional money going in.

Mr Bax: I guess we could only see that when we know really what these funding envelopes are going to be and what they entail and how they are there.

1450

Mr Wessenger: Fine. Thank you.

Mrs Fawcett: Thank you for coming. You've done very well. You don't have to worry about coming before a committee at all.

Certainly, my questions were in the same area as the parliamentary assistant's. On this whole classification system, the case mix study, I was interested to know whether you thought that study was adequate. But of course you can't answer that because you haven't got any results and you don't know, really, what the results mean when you do get them. As you said, you want to see the whole picture. It's like we've got the title of the picture, but we don't have anything but the very little bit on the canvas.

Maybe if I could just go a little bit further, a year is a long time too, if you're doing this yearly, to the next patient

classification. Do you foresee this as a problem in that the patient may go up two or three levels of care in that year and yet you're only funded for what it was before? Do you see that as a potential problem, being that you do have a nursing home with patients and clients who may not be that well?

Mr Bax: I am not sure whether it will be or not. I'm not overly concerned with that particular aspect because if I take a look at the turnover of residents—but my point is that when placement coordination does the eligibility criteria, then it becomes extremely important. If I'm losing a classification 6 person, it would be nice if I could simply ask them, "The resident that you are proposing to place, could you tell me the classification that they are in?"

Equally, what could happen if that's not done is that if one facility has a particularly high turnover and they've got all 2s or 3s, they could very well be overloaded and that could really affect them. So there should be some kind of element in the placement as we do this together to try and bring that balance and to keep each home relatively at a constant level of average care that's required. I'm much happier with what we're doing now, but I need to really see it work for a little bit to see how ultimately it is going to be

Mrs Fawcett: Thank you. I think those points are very good brought forward.

The Chair: Thank you very much. One point: I'm just informed that the case mix index study is supposed to be available in March. Now, March is 31 days, but I'm told as soon as possible in March. So I leave that with you.

Mrs Caplan: And are we going to have the chronic care role study in March? March is going to be a big month.

The Chair: March is the cruellest month. No, that's wrong. April is the cruellest month.

Mrs Caplan: What happened to the Ides of March?

The Chair: We're just practising our poetic references. Again, I want to thank you very much for coming before the committee. We are glad that you came over.

Mrs Caplan: An excellent presentation.

The Chair: I would now like to call the representative from Chelsey Park Retirement Community. While that person comes forward, could I just ask if the following might identify themselves to the clerk if they are here in the audience: Victorian Order of Nurses, Sarnia-Lambton; Victorian Order of Nurses, Oxford County; Southwest Regional Centre Auxiliary. If there is anybody from any of those three groups, could they identify themselves to the clerk. We know that the representatives from St Joseph's Health Centre are here. Thank you.

CHELSEY PARK RETIREMENT COMMUNITY

The Chair: Thank you very much for coming before the committee. Would you be good enough to identify yourself for the committee members and Hansard, and then please go ahead with your presentation. We have 15 minutes.

Mr Tony Orvidas: Thank you very much for allowing me to come today. My name is Tony Orvidas. I am the administrator of Chelsey Park Retirement Community,

which is a for-profit long-term care facility which includes a nursing home, retirement home and seniors' apartments. I'm employed by Diversicare Management Services, which is a company that operates nursing homes and retirement facilities in Canada and the United States.

As the newly elected chairperson of the Ontario Nursing Home Association, region 7 professional advisory committee, I also represent approximately 57 nursing homes with 5,000 extended care beds in southwestern Ontario. I also have experience managing municipal homes for the aged. Much, if not all, of what I have to say you probably already have heard or will be hearing. I'll therefore try to keep my remarks relatively brief.

I'd like to preface my remarks, by the way, by asking you to keep in mind two very important points, the first being client self-determination and consumer choice, as I think it's a very credible issue, and the second being equality of treatment, that basically being an end to the discriminatory funding practices of the province for the last number of years. I believe you're well acquainted with that.

You will no doubt be hearing from other groups and individuals who are trying to either delay or maybe even derail long-term care reform, but neither I nor the nursing home association is one of them. Our concerns basically pertain to the wording of portions of this particular bill, Bill 101, and its omissions. We want to see the bill passed and, after it is amended, a new funding model implemented as soon as possible, if not sooner. Since 1990, we have been waiting for an illogical and unfair funding and regulatory system to be corrected, and we're still waiting, as you well know.

While we are very pleased that the government of Ontario has attempted to develop the same set of rules in a more equitable treatment for all long-term care facilities, we are nevertheless concerned that there will no longer be a universal, accessible approach to health care in nursing homes and homes for the aged. We're concerned that there appears to be no government accountability to maintain equitable and consistent services to meet residents' needs across all of Ontario. We're also concerned with the role of the placement coordinator, the lack of choice for applicants, and the lack of appeal for applicants for placement. That's where this client self-determination is particularly important.

Also, we are wondering whether placement will be available 24 hours a day, seven days a week, as is expected of us. We believe facilities should have an appeal mechanism to challenge placement recommendations when a facility believes that it cannot meet the care needs of the applicant both safely and properly.

We are also concerned that the bill sets up a more adversarial approach than the current Nursing Homes Act regarding inspections and the general relationship between government and facilities. The power of inspectors should not be increased, and the use of the existing compliance management program, which barely got off the ground before it was shelved, should be continued. Also, we believe the role of the advocate should be clearly determined and

we need to identify where that fits in terms of the role of the inspector and the self-determination of the client.

In summary, the bill leaves too many issues to regulations. It provides too much power for the government and its inspectors without requiring a corresponding measure of accountability. The bill holds facilities accountable for providing for all residents' needs without ensuring that funding will be provided to make this possible.

We believe we must all go forward with the bill as soon as possible, since our residents, the residents in nursing homes, have been waiting too long already for discrimination to end. The nursing home association professional advisory committee, region 7, is prepared to work with government and others in partnership to make this long-awaited process of reform both successful and timely.

In closing, I'd like to thank you for your time and for your attention.

The Chair: Thanks very much, and congratulations on your election to your position. We'll begin the questioning with Mr O'Connor.

Mr O'Connor: I want to thank you, of course, for coming today. We certainly do, when we travel the province in a legislative committee like this with a piece of legislation, hear a wide range and varied number of views around the legislation. Of course, everyone would like to have seen things happen yesterday, and unfortunately that isn't the case.

You've spelled out some concerns that you have around the placement coordination, and that's where Γ d like to pick up from. Are you currently serviced through a placement coordination service now?

Mr Orvidas: Yes, we are, at Chelsey Park.

Mr O'Connor: Who provides that placement coordinator—

Mr Orvidas: The Thames Valley placement coordination service.

Mr O'Connor: Do you have problems with that placement coordination?

Mr Orvidas: Currently, any problems we do have are really quite minimal in that they are not only flexible but I think quite accommodating in taking into consideration the levels of service we believe we can provide, in terms of understanding when we have to deny admission to Chelsey Park by clients we feel we cannot serve appropriately, whose needs we cannot meet, also in terms of being quite flexible when it comes to someone from one the residential suites in our retirement home wishing to move into the nursing home when he or she is ready and requiring extended care services.

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Mr O'Connor: That's good. I'm glad to hear that. I know we've heard concerns around that from a lot of people. I know the right for consumer choice, and the consultation paper that went out last year certainly pointed out some very strong principles, and of course when you take a look at legislation, not being lawyer, it's sometimes hard to see where they put the principles in. Maybe we're going to have to try to work on them to bring out some of

the principles and maybe a statement of principles or something.

The placement coordination does seem to be a bit of a problem. But in areas that do have the placement coordination we've heard from a lot of people who say that it does work, that they usually take into consideration the wishes not only of the clients but the ability to serve that clients in the facility they would place them in. It seems to be the case that it's working well here. Perhaps then we should take what we've learned here and make sure that does get applied if we have to go into areas without placement coordination.

I thank you for coming to the committee and bringing those views forward.

Mr Orvidas: I believe it does work well within current legislation and within the current limits to what they are permitted to do. I have a concern with the new legislation and the lack of accountability that seems to be evident.

Mr O'Connor: Do you think the placement coordinators need more accountability, and in what areas would you see that?

Mr Orvidas: I would request that there be greater information provided regarding appeal processes and the opportunity for clients to have more choice.

Mr O'Connor: I think that as we go along further into the process, that will become available. I know that in the draft manual that was circulated around the province—and of course that was only a draft—looking for comment to try to improve it, I believe OANHSS, from the non-profit sector, did hold consultations with people from their organization to try to get feedback directly from them, because of course everyone's concerned about how it will all come together.

The Chair: Thank you. Ms Caplan.

Mrs Caplan: Thanks for an excellent presentation. I have a number of very short questions. Do I have to roll them all into one or can I ask them sequentially?

The Chair: The Chairman will pretend they're all wrapped into one, as long as they are short.

Mrs Caplan: They will be short.

We've discussed an amendment that would allow all long-term care facilities the right to refuse on the basis that they couldn't provide appropriate care. Would you support that?

Mr Orvidas: Yes.

Mrs Caplan: As well as the right to appeal that right to refuse?

Mr Orvidas: Correct.

Mrs Caplan: Do you think there should be a statement of principles embedded in the legislation around consumer choice that the placement coordination services would have to consider—I read them into the record this morning—all of those things: multicultural sensitivity, geography, dignity? There are a number of them. Would you prefer to see that in legislation or in regulations?

Mr Orvidas: A statement of principles or a mother-hood statement of that nature I think is always good, not only in legislation but in any guidelines or standards.

Mrs Caplan: The suggestion that we could change by amendment the proposed enforcement model of accountability to one which would mandate a program of quality management, be it total quality management or continuous improvement, plus a mandated requirement for accreditation and then, upon complaint, you would kick into a compliance mode of cooperative problem-solving rather than having that enforcement model which requires all of that paperwork and reporting: Would you support that instead?

Mr Orvidas: That sounds very interesting, and I think moving towards more of the type of the model we'd like to see

Mrs Caplan: The other concern I have, and you mentioned it, is the amount of paperwork that the enforcement model breeds. We know that the whole concept of our total quality management approach looks at processes to eliminate excessive reporting at the same time as keeping good records so that you can monitor your outcomes. That's a progressive and modern way to do it. How prevalent is that, do you believe, in the nursing home sector? We've heard about it from so many people who have come forward, and I know that's got to be relatively new in the last two to three years. Do you think most nursing homes have those programs in place now?

Mr Orvidas: The vast majority of nursing homes are currently accredited, and one of the integral components of the accreditation process is the requirement for not only quality but risk management, TQI or CQI, total or continuous quality improvement or whatever you might like to call it.

The Chair: Final question.

Mrs Caplan: They're monitoring their programs as well as their management on the basis of result, outcome?

 $Mr\ Orvidas:$ It would appear to me that they're doing both.

Mrs Caplan: Thank you.

Mr Jim Wilson: Thank you very much. I too would like to add my congratulations and I wish you all the best as the chair of the nursing home association.

Mr Orvidas: Just the region.

Mr Jim Wilson: For the southwest region?

Mr Orvidas: Region 7.

Mr Jim Wilson: It will be an onerous task, I'm sure, given all the changes that are happening in the sector.

I want to just comment that although there have been problems from time to time in the past, you're currently under a fairly onerous and time-consuming inspection system. You mentioned in your comments that you felt there were some increased powers of inspectors that this bill provides for which may be problematic. I just want you to sort of enlighten us on what those increased powers may be and some examples of how they may be problematic for your sector.

Mr Orvidas: The current compliance management program compared to the old style, if I may, of inspection process I think has not only worked towards improving resident care but improved or significantly improved relationships between the Ministry of Health and the individual nursing home operators and managers. It's a consultative, cooperative approach to doing the best we can within the resources we have available, rather than being beaten over the head because a set of curtains is two inches too high or a door opening needs an extra five inches worth of opening, or something to that effect.

Having had experience in homes for the aged, the process of working with program supervisors I thought was always a very positive one. However, from that perspective, I always found that there was not enough accountability, while with nursing homes the other side presented itself: extreme and excessive accountability.

Mr Jim Wilson: Thank you. I think Mrs Cunningham has a short comment.

Mrs Cunningham: Just one statement to you, Mr Chairman. This again is one of the great administrators of one of the good facilities here in London, and I wanted to draw it to the attention of the committee, but mainly because he was probably the first one, within a few days of my getting elected, who made certain that I got out there and found out how his facility operated. I just want all of you to know that and I'm not surprised to hear—

Mrs Caplan: That's probably why they elected him chairman.

Mrs Cunningham: Chairperson.

Mrs Caplan: Right.

The Chair: We're delighted that somebody got the honourable member out there—

Mrs Cunningham: Yes, I'm not surprised. He does everything.

The Chair: —and doing something, because that would make us terrific.

Mrs Cunningham: Mr Wessenger, you should phone this man and get some better advice than what you're getting, and you wouldn't have this written the way it is.

Mrs Caplan: It's not that he's getting bad advice—

The Chair: Mr Orvidas, you have obviously been placed, now, on a certain pinnacle.

Mr Orvidas: Yes.

The Chair: We thank you very much for coming.

VICTORIAN ORDER OF NURSES. SARNIA-LAMBTON BRANCH

The Chair: If I could then call for the representatives of the Victorian Order of Nurses, Sarnia-Lambton branch, and after they present, I believe the representative of the VON for Oxford county is also here and she will be next up.

Thank you very much for coming to the committee today. We very much appreciate it. If you'd be good enough to introduce yourselves for members of the committee and for Hansard, then please go ahead with your presentation.

Mr Jack Smith: First of all, it's a pleasure to be here today to make this presentation to the standing committee. My name is Jack Smith, and I'm the president of the board of directors of the Sarnia-Lambton Victorian Order of Nurses. Accompanying me today is Lavinia Dickenson. She is the executive director of the branch in Sarnia.

The Chair: Welcome.

Mr Smith: We have a handout here. Do you want it before we give the presentation?

The Chair: Yes. The clerk will get that and distribute it. Thank you. We've just been discussing paper, so I think it's appropriate that we should distribute some. Please go ahead.

Mr Smith: VON Sarnia-Lambton is one of 33 branches in Ontario and administers the following programs.

The visiting nursing program: Registered nurses and registered nursing assistants will make approximately 65,000 visits this year to a high percentage of clients requiring acute care, such as intravenous treatment therapies and palliative pain control. Foot care clinics are offered throughout the county, along with an active shift nursing program.

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We have a volunteer services program and 200 dedicated volunteers provide transportation, friendly visiting services and palliative support. Volunteers are also involved in office administration, along with fund-raising and educational events. We also administer the home care program. We are one of the four branches in the VON that do this. Along with this we administer the placement coordination service, which assists families and hospitals in determining the appropriate level-of-care service for those needing long-term care placement.

In keeping with consumer rights, we at VON believe that individuals have a right to access comprehensive, compassionate family and community-centred health and support services. Health care providers and consumers then collaborate to develop, implement and evaluate services.

I'd like to make a few comments under a few headings. The first one is funding and cost containment. We believe that the health care system as a whole is adequately funded, but management of the system needs attention.

A provincial strategic plan should be developed, with funding allocation based on strategic priorities. The government should take a look at where the growth is and stage its funding allocation accordingly. This year in Ontario, for example, there has been a significant increase in the Ontario drug benefit, 3%, in physician costs, 4%, while hospital increases are being contained and there is a possible 0% increase for community-based services.

Funding community-based, long-term care as an alternative to inappropriate use of acute care resources and institutionalization is certainly a step in the right direction. But the government should ensure that there is a viable funding base in the community to sustain the proposed shift. This can be achieved by financing the increase in long-term care by staged reallocation of the existing health care budget. We recommend that the government give serious consideration to building in accountability for

consumers and providers for appropriate use of our limited health care dollars

To support community-based care, certain core programs should be in place. We are certainly pleased to be a community that will be receiving the integrated homemaker program. Other program initiatives might include respite for care givers, in-home palliative care and foot care. However, new programs should be designed to include outcome measurements in the evaluation process.

VON Sarnia-Lambton is interested in moving towards the provision of homemaking services which will provide integrated services for clients who require multilevels of care. The Sarnia-Lambton branch would be interested in and pleased to participate in a pilot project of a comprehensive multiservice agency model.

Under planning, VON supports the government's direction to be as inclusive as possible when discussing the needs of the disabled, and recommends that the needs of the physically challenged, children and adults with chronic disease and high-risk elderly be given equal consideration.

Planning responsibilities should be clearly defined, with the recognition that the further away decisions are made, the more things get lost. The real authority should be closer to the people. Planning provincially, regionally and locally with clearly defined responsibilities will improve efficiency. For example, provincial responsibilities should include the definition of core programs and the formation of a quality management framework, including standards, outcomes and reporting requirements. Regional responsibilities should include specialized service planning, ie, geriatric assessment and specialized rehabilitation resources, while local planning should include the continuum of care from health promotion through rehabilitation at all levels of service delivery.

The lead role for local planning shoud be assigned to the expanded district health council with enhanced social service representation.

Under the allocation of resources, at this point in time the government has been considering the question of devolution of the responsibility for health and social services to local agencies. This is in follow-up to the recommendations of the Premier's Council that recognized the need to have a more flexible and responsive health and social service system in Ontario.

VON would support a government initiative to pilot the devolution concept with long-term care. The envelopes devolved to the local authorities should be inclusive of the long-term care budget, ie, include in-home services, community-based and facility services. This will allow for the flow of funds between the community and the institution, as it is in the best interests of the local community. It may also allow for rationalization of the service delivery.

Under coordination of long-term care, while there may be several agencies providing service to a client, this system can be managed to ensure that the service delivered is seamless. Long-term care services should be available 24 hours a day. Traditionally, clients needing care after normal working hours have access to care through hospital emergency departments. It is consistent with the devolved authority model and quality management practices to

empower front-line staff in the provision of appropriate customer-focused service.

We would make these following recommendations pertaining to Bill 101:

— VON recommends that consumers have a choice of whether to receive needed services in a facility or a community setting within an envelope of available resources. In short, the consumer has a choice of service location.

— VON also recommends that if the consumers require and they or their surrogate decision-maker choose facility care, they have the choice of what facility to enter, rather than this being the decision solely of the placement coordinator.

— While supporting the incremental changes proposed to protect and increase the involvement of the consumer in their care, VON recommends that the tone of the amendments be empowering rather than paternalistic.

— VON recommends enhancement of health promotion and community care options rather than moving ahead on Bill 101, which sends a message that the government is still more interested in institutional care.

— Therefore, VON recommends that the Bill 101 amendments be delayed until the publication and public debate on the government's long-term care redirection policy framework has occurred.

The Chair: Thank you very much for your presentation and for your recommendations. We'll begin the questioning with Ms Caplan.

Mrs Caplan: Thank you for an excellent presentation. We've heard from a number of VON organizations with the same recommendation for delay.

What we have heard from the parliamentary assistant is a best efforts commitment to the month of March, giving the framework for long-term care, the month of March producing the chronic care role study and now we've heard about the month of March having the classification information available as well.

What I would like to know from you at this point, since we've heard from so many people how important it is—it's been two and a half years' wait from when this originally had hoped to be implemented—would you reconsider your recommendation for delay if some of the amendments that had been proposed—I know you've been here for a little while hearing about some of the amendments that would deal with the paternalistic enforcement, the outdated ideology that's in the legislation—if some of those changes were made and with the commitment that the rest of the package is going to be available in March?

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The Legislature, we don't think, is coming back before April or early May. It is likely that this legislation, even though it is entirely institutional in its focus, with the exception of the support for disabled persons—I think that's a very important part we've heard; nobody wants delay in hat—likely this legislation will not be dealt with until the spring session. May or June would be my guess. Would you reconsider your recommendation for delay in light of all of the evidence that says we should get on with this?

Ms Lavinia Dickenson: My sense, having worked in the community as long as I have, is that I'm not convinced that the changes will be forthcoming, in that we have been waiting at least three and a half years or more. I think it's imperative in order for local planning to occur. The health council has just recently received this role and certainly isn't necessarily in a position to take on this role in view of the fact that the chronic care role study isn't a piece of any of this. They have a big impact on the system, and certainly if they weren't included in Bill 101, then entry into chronic care could be a back door into the long-term care system.

Presently, the acute care is an entyr into the long-term care system in a lot of cases, and I think that's a valid concern. So before I would say yes, I'd go along with that recommendation, I'd really like to see the policy framework as to how those other pieces are addressed.

Mrs Caplan: Can I ask one more?

The Chair: One.

Mrs Caplan: If the policy framework says that the chronic care role, or that facility should become a long-term care facility and be included under this framework, would that solve your concern from the institutional side?

Ms Dickenson: That would solve it. Yes, that would solve my concern on the institutional side because, theoretically, reading Bill 101, there would be very few people who will need a chronic care bed for all intents and purposes.

Mrs Caplan: Similarly, we'd need the framework to see how you would have the support and resources, of course, for the community components of it.

Ms Dickenson: That's right.

Mrs Caplan: But my concern is that if this sits for too long and we have delay after delay, the patchwork, inequitable, awful system—when I say "awful," it's just so unfair—that exists today would be allowed to continue for too long. Thank you.

Mr Smith: I guess our concern, though, is that we would not like to see any of this come in in a piecemeal style.

Mrs Caplan: I understand.

Mr Smith: That's our concern.

Mr Wessenger: Thank you very much for your presentation. I can see by your brief that you're well on the way to being a multiservice agency at present. I'm just wondering what changes would be required in order to make you a complete multiservice agency.

Ms Dickenson: We want to be able to provide a homemaking service not necessarily for every person who's on service but for a certain stream, maybe the palliative care person because his needs are fairly complex and need to be highly coordinated.

We also need to recognize that there have to be enhancements for folks being on call, going out in the middle of the night into strange parts of the city. There are safety features that need to be built in to do these things. While we are providing intravenous therapies and things like that, there needs to be some consideration for the ongoing recertification of staff and trying to keep people interested and working in the community, and it's a changing role as well.

Mr Wessenger: You indicated that you're interested in having a pilot project. Will you sort of be working on that with respect to—

Ms Dickenson: Oh, yes.

Mr Wessenger: Fine. Thank you.

Mr Jim Wilson: Thank you for your presentation. I'm glad the parliamentary assistant asked that question about the pilot project. Your end of the deal would be to keep lobbying for it. What your end of the deal is, Mr Wessenger, are you going to have a pilot project? I might as well ask you that question.

Mr Wessenger: You shouldn't be asking them.

Mr Jim Wilson: Seriously, has the ministry contemplated how it's going to go about the new system, and is there to be a pilot project?

Mr Wessenger: Of course, it's going to work through the long-term care subcommittee of the district health council, but I think I'll probably ask the ministry staff, who can probably give more detail that would be of assistance in this regard.

Mr Quirt: In our December 2 announcement to the Legislature, the then Minister of Health, Frances Lankin, indicated that the intention of the redirection was to bring together service coordination functions with actual service delivery functions.

What that really means is that the resources associated with the home care program and the resources associated with the placement coordination service program—the people, the skills and the financial resources—would be brought together with the resources of those agencies delivering services, like Meals on Wheels, transportation, homemaking services and visiting professional services to form a comprehensive, multiservice agency. The minister has asked district health councils, through their long-term care subcommittee, to establish the appropriate planning process so that those options can be considered and that it be done in an orderly way locally.

We expect there will be a variety of different models of comprehensive, multiservice agencies. Some may involve the actual bringing together of agencies under one board. Another model that has worked well, on a county basis, with home support programs is the creation of an umbrella board to which local service providers send representatives, and that could form the multiservice agency. So a small agency that used to just deliver Meals on Wheels could have the capacity, right at that spot, to determine that somebody's eligible for a professional health care visit and arrange for a physiotherapist or a nurse to go out right from that location.

The notion is to equip each portion of the community service system with a mandate to provide a much broader range of services than it can now. As I mentioned earlier, it's a responsibility of the DHC to figure out how many are necessary in their area, where they'd best be located and how they best be configured, but it is not the intention to do it on a pilot basis. The policy decision to move in that direction has been announced.

Mr Jim Wilson: Thank you. I appreciate the explanation as I'm sure the presenters appreciate it.

I do want to ask you—I gather that part of VON's recommendation to delay the legislation is probably the fear that the community-based services won't be in place. We've had 5,300 hospital beds closing since this government came into office, 2,800 ONA nurses—that's the only number we have that's solid—laid off, some VONs laid off around the province and public health nurses laid off. Perhaps, while you have the opportunity, you can give us the lay of the land in Sarnia-Lambton. Are you able to meet the current demand? My theory is that with all these layoffs, the crunch is not too far down the road. Are you going to be able to meet that expected crunch?

Ms Dickenson: I think we've seen the right-sizing of hospitals maybe later than other communities, so we're just beginning to see this now with bed closures.

Our particular VON did not experience any layoffs. The layoffs that were experienced with other VONs were due to the fact that they brought RNAs on stream to diversify the workforce, so that didn't really happen in our area. For the most part, we're able to meet demand except that we're having some difficulties within our fiscal framework in providing on-call services.

For instance, shift nursing right now is being funded through private insurance companies. Certainly folks needing palliative care who do not wish to be admitted to hospital require the services around the clock lots of times. We're trying to fill those needs by fund-raising and filling the gaps, and of course in our economic realities that's not always easily done either.

Mr Jim Wilson: There are a lot of groups competing for the fund-raising dollars out there.

Ms Dickenson: Yes. There are a lot of miracles that are expected by community health agencies, and a lot of fiscal acrobats.

Mr Jim Wilson: Probably because the VON's been traditionally good at performing those miracles.

Ms Dickenson: Thank you.

Mr Smith: I guess the other thing too is that this year we have increased to about 65,000 visits, so it's not that we haven't taken on RNAs as well; we certainly have. We have RNAs as well, but because of the increase in visits, we've been able to take on the RNAs and hold our nursing staff to the same. In fact, we're projecting, probably, for the next year in the neighbourhood of 73,000 to 74,000 visits.

The Chair: Thank you very much. We would wish you continued success with miracles and success with the pilot project, however it may be called.

Mr Smith: We have talked to Bob Huget about it and we will continue to talk to him. Ha, ha.

The Chair: The truth will out.

Thank you again very much for coming before the committee today. We appreciate it.

Ms Dickenson: Thank you.

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VICTORIAN ORDER OF NURSES, OXFORD COUNTY BRANCH

The Chair: Could I then call the Victorian Order of Nurses, Oxford County branch. If I might, I would just note to committee members that we are right on time, and I appreciate the cooperation of members as we proceed through the afternoon.

Thank you for coming to the committee today. Would you be good enough just to introduce yourself for committee members and Hansard, and then please go ahead with your presentation.

Ms Kathryn Bamford: It's important to know, firstly, that although all the VON branches belong to the provincial—

The Chair: I'm sorry. Could you just introduce yourself first, for Hansard.

Ms Bamford: I'm sorry. I'm Kathryn Bamford. I'm the executive director of VON in Oxford County.

As I was going to say, it's important to note that although all VON branches belong to a provincial and national organization, each branch is incorporated on its own and has unique concerns which reflect the unique community that we serve.

VON in Oxford county recognizes the need for long-term care reform and encourages a collaborative approach to planning and implementation of an enhanced health care system which will continue to provide a quality continuum of care within the limited resources available. I ask your tolerance in listening to some of the repetitious issues that you'll be hearing in my presentation which you've heard with VON Sarnia-Lambton.

Good afternoon, Mr Chairman, standing committee members and interested public. I've been asked to speak to you today on behalf of VON Oxford's volunteer board of directors, who are busy with local community commitments and are not able to be here today. As executive director of the branch, it is my pleasure to do so.

As indicated in my opening remarks, we support the need for improvements in the long-term care system. Rather than reiterating the realized benefits of Bill 101, I shall highlight further enhancements required in the areas of vision, planning, allocation of resources and service delivery which will ensure a comprehensive system reform absolutely necessary within the economic realities of today.

VON Oxford believes consumers requiring long-term care services to promote their health and wellbeing need to have a choice of needed services delivered in their preferred location, by their preferred provider, within available resources.

Bill 101 supports some of the incremental steps towards a consumer- sensitive system. However, if we really believe in consumerism, then we must allow people choices. Firstly, we must be all-inclusive. Bill 101 has not addressed the chronic-care bed population. Secondly, we must create opportunities. Bill 101 needs to include requirements for residents' councils in all long-term care facilities. Thirdly, we must ensure the right to exercise choice. Bill 101 needs to allow individuals the choice of whether to receive

needed services in a facility or a community setting within an envelope of available resources.

In recognition of the consumer's right to self-determination, consumers should have the opportunity to participate in the decisions that affect them.

VON Oxford believes more emphasis should be placed on the rights of consumers to be a full partner in the planning of care, including the delivery model and the provider best suited to meet their needs, as well as to be a partner in the evaluation of the service provided.

Bill 101 needs to ensure a preference for not-for-profit service options for individuals due to the return value to the community by way of volunteer contribution of time and resources and community accountability. Bill 101 needs to ensure that consumers' participation is not contrived, controlled, or an act of tokenism.

A provincial strategic plan needs to be developed with funding allocation based on strategic priorities. Certain core programs need to be in place to ensure provincial equity, particularly in a small rural county such as Oxford, which often lacks a critical mass large enough to support some specialized services. We are therefore forced to accept less than the best services available or sometimes to travel 45 kilometres to London, if able. Community-based core programs should include the integrated homemaker program, which we already have; respite for care givers, which we are in the process of acquiring; in-home palliative care, which we presently have; and foot care, which is necessary to keep vulnerable people mobile and independent, which we also have.

District planning requires involvement of the district health council, particularly the long-term care committee. Already our Thames Valley District Health Council long-term care committee has restructured to include 48% consumers and a broad base of community providers. Local health and social planning has begun in Oxford as well, thanks to the insight and inspiration of our local MPP. Kimble Sutherland.

VON Oxford believes the real authority must be closer to the people. As this authority moves away from people it is intended to serve, it becomes less sensitive, and important detail is often lost.

By moving ahead with facility legislation outside of the policy framework and prior to local district health council planning, the government is not fully supporting its own direction for a strategic policy-based approach to the health care system based on consultation.

Funding community-based care as an alternative to inappropriate use of acute care resources and institutionalization is a step in the right direction. However, we in the community require assurance that there is a viable funding base in the community to sustain the proposed shift.

In Oxford county, collaboration between all health and social sectors would be enhanced by the devolution concept, with long-term care including both in-home services, community-based and facility services. We would support being involved in piloting the devolution concept, as with VON Sarnia, given that the agency, having the envelope, reflects community services, consumers, government and a broad-base representation from providers. It is important

as well that no one funding model be attached to the terms of reference for devolution. Rather, there needs to be flexibility of payment modes available to allow for the most cost-effective alternative, given the nature of the service.

The legislation promotes fiscal accountability by a control on resource utilization rather than on the measures of resource outcome. Efforts to control the number and types of beds and associated costs continue to be sectoral and need to be expanded to evaluating the benefits of facility versus other types of care from a broader perspective, as well as consumer input. If total quality management is achievable, we must plan a system which ensures accountability rather than one which continues to control and regulate in a sectoral, fragmented fashion.

Seamless service delivery appeals to everyone wanting to correct the fragmentation in the service system. The how-tos of this have created some degree of concern among traditional stakeholders as we local providers attempt to collaborate in spite of the barriers of the present systems. These barriers require further attention in the long-term care legislation in effort to reduce institutional bias.

VON Oxford suggests that the development of comprehensive multiservice organizations funded by capitation may significantly reduce the bed requirements by providing more comprehensive, potentially cost-effective options in the home. VON Oxford is evolving by responding to community needs through seven programs and services. Clients already experience the benefits of comprehensive care, from the least intrusive volunteer services, such as Meals on Wheels and friendly volunteer visiting, to more professional supports and needs, from foot care and RNA nursing care to home IV therapy and palliative care with pain control technology supports. Our network of health and home care social service partners such as Red Cross homemaking, hospice and placement coordination, provides clients with a continuum which particularly benefits those with complex needs in a cost-effective way.

VON have realized the benefits of collaboration in Oxford county in planning and implementation of services. We continue to view health in a broad way, encompassing health and support care in an environment of continuous quality improvement. We are encouraged by the directions set forth by Bill 101; however, we recognize the need for public debate on the government's long-term care redirection policy framework prior to finalizing Bill 101 amendments. This is a necessary conclusion to the consumer public consultation.

On behalf of VON Oxford, I'd like to thank you for allowing me this opportunity.

The Chair: Thank you very much, and thank you also for offering another pilot project. We'll keep a list of—

Ms Bamford: Add it to your list.

1540

The Chair: Who's on line here? We'll begin the questioning with Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. I just want to focus, really, on one point that you mentioned, because I think there's still some considerable debate around the area of cost and providing in-home services,

community-based services. Some would argue that when you get into really high levels of care, it's not necessarily cheaper to provide that care in the home because of the machinery required and the capital and all that.

I've never seen a cost-benefit study. We've gone along, and I think all politicians have given a lot of speeches about the move towards community-based care, but we really don't know—at least I don't—at what point it makes sense to keep people in their homes and when it makes sense to maintain some institutional care.

Do you have any comments on that? You're out in the field; you have experience. We've not seen the studies. We're kind of doing a lot of this in a vacuum, as you might be aware.

Ms Bamford: I'm not surprised. It's a very complex issue because there are so many variables to consider.

The only thing I can perhaps reference is that we actually were fortunate enough to be involved in a case whereby we were maintaining a medically fragile child at home. The child really had two options: to stay in London in hospital, or to come home with what limited supports we would be able to provide in the community.

We did a little bit of costing on that, and I can't recall the numbers specifically, but I can tell you that within a two-year period, that child was reduced to 11 hours of respite a week, and I could actually provide this committee with that report.

Mr Jim Wilson: That would be very helpful.

Ms Bamford: It was a very interesting study because this child had very complex needs, and the child relied very heavily on the parents providing a great deal of the support. I would say that would be very much one of the factors for anyone who is going home requiring intensive care, in that it's very difficult to provide specialized nursing care 24 hours in the home in a cost-effective way. However, there are many cases where care givers are willing to do and provide a great deal of that support. I think that's where we see in-home services being very cost-effective, with either family and/or volunteer services such as hospice or volunteer visiting services or Meals on Wheels.

Mrs Caplan: There is an improved quality of life as well in that situation.

Ms Bamford: Absolutely.

Mr Jim Wilson: I think we agree with that, and the VON has been very good to sort of train the parents and help them learn some skills that they may need. I guess the problem we run into as legislators with the changing demographics and the changing nature of families is you have to make sure there are people at home willing to help out and able to help out, and that's a problem, too.

Ms Bamford: That will become, I think, very much a part of the assessment. What are the supports, who are the supports, and what are they willing and able to do? That's very critical. That's a very critical factor.

Mr Jim Wilson: Thank you very much.

Mr Wessenger: Thank you very much for your presentation. I'm going to ask a question you won't be able to answer in time, so I'll just ask you to touch on it.

You've raised the whole question of devolution. I'm wondering to what extent you mean devolution. Do you mean planning functions? Do you mean management functions or partial management functions? How do you see the role between local and provincial? Lastly, how do you hold the local role accountable?

Ms Bamford: How I try to look at this is from the individual op, knowing that again, decisions made closest to the individual are the most sensitive to his needs. I'm thinking that locally, in Oxford county, we have our health and social services planning council. We're in a very early stage of developing a model for that, but I see that council as being very much a representation of all health and social service providers in Oxford county. It's broad-based in terms of provider representation and it's broad-based in terms of consumer representation. These people really, given an envelope of funding, would be able to look at how we distribute the dollars locally and they would be accountable to the decisions that are made. If, for instance, they spend too much on in-home services and when they need to get into the hospital there's a six-month waiting list and the public is upset about that, this group would be accountable to answer to that. Now, whether it's elected or appointed, those are all other issues that have to be dealt with. But I think the only way we're going to have devolution is if the funding be at the local level.

I also believe there are some things, just as I indicated in my presentation—we do not have the economy of scale to have a cancer clinic in Oxford county. We realize that and know there are some things that need to be looked at in a regional way.

We also know there are some things, again, that need to be planned regionally as well as some things, perhaps such as transplants, which would need to be planned and administered provincially.

I'm looking at all of those layers and I'm saying it has to go both ways, though. The planning has to come from the bottom up and from the top down, and they have to be able to look at where the economies of scale are and the efficiencies that can be acquired in that system.

Mr Wessenger: Can I just follow up? How would the district health council relate to this local authority? Are you looking at this local authority being an expanded model of district health councils?

Ms Bamford: I see it as being a tentacle of the district health council, very much a part of it, because of course they have the responsibility to plan and they have the resources and the information that's necessary to plan. I don't think this body would detract at all from the district health council. In fact, I think it would be an enhancement. Already many of the people who are involved in the local planning are also involved either as council members on Thames Valley District Health Council or are acting in an advisory capacity on the committee. So there's already that cross-referencing.

The Chair: Ms Caplan.

Mrs Caplan: I'd like to use the few minutes I have to give you an example of what I'm dealing with on behalf of one constituent right now, which I think tells a story that

needs to be told when we're looking at these kinds of reforms. I just have a few minutes.

I had a call from a constituent's wife about a week and a half ago. Her husband is recovering, fortunately, from a stroke. He's in a chronic care hospital. He's recovered to the point that he can go home and he wants to go home. He's upset and distressed about being separated from his family and his home surroundings, and his wife wants him home. He was told, and his wife was told, that he had to remain as an inpatient in order to receive one hour a day of speech therapy. I see by the look on your face that you can understand the frustration of this woman. It was so distressing and upsetting to her that she called me to say: "He's upset. He's depressed. It's costing a fortune to keep this man in an inpatient bed, but they've told us that if I take him home, he won't be able to get the service because he's not an inpatient."

There's no placement coordination service. What I did was to call the administrator of the hospital and say, "Couldn't you give him a day pass so that he could go home, spend the time with his family and come back for the one hour a day of his treatment?" He said, "We'll look into this"

The next thing I heard was that the patient had been transferred to another chronic care hospital where he was now undergoing another assessment, which took three days, to determine what his need was. At the end of the second assessment, it was determined that he needed one hour of speech therapy a day, and he was informed by the second chronic care hospital that he had to receive this as an inpatient and could not be given day passes and so forth to go home because this was contrary to the institutional rules.

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Long-term care reform, I think, is about trying to be more responsive to those kinds of individual needs. My question to you is—and obviously you've dealt with the kind of individual and patient and spouse and family in this kind of situation—can you see a better way? Will Bill 101 respond to that kind of situation? Because clearly these services—one-on-one speech therapy, one-on-one physiotheraphy, occupational therapy for a stroke recovery victim—do not have to be provided on an inpatient basis in a chronic care hospital at an expensive \$800 a day, \$400 a day. What would it cost—you would know—for VON to contract for a speech-language person to go into that patient's home to deliver that service for an hour a day?

Ms Bamford: Actually, I wouldn't know, but I could make a guess and it would be significantly less. I think what that problem illustrates is the way we've fragmented or we've sectorized, if we have these pillars of institutional care and different types of services. There's been a certain tolerance in the system. In fact, it's fostered that because of the way the pockets of money have been separated. Children's services are an example of this, where children have to wear certain labels to access certain pockets of money. It's gone from the sublime to the ridiculous. I think the only way that we're going to eliminate these problems is if we break down those barriers. I don't know whether it

means dismantling all these boards and collapsing them into one. Whatever it is, it's making people accountable to the continuum and not just to their own sector.

So then the problems have to belong not to just that sector. The problems have to belong to the continuum. That's why we keep supporting locally the health and social support services together. It's very important, because if we think of health care and disease care and health promotion, one does not stop when one goes into—Meals on Wheels, being a social support, is very much a health service. It's hard to know where the blurring of those two areas occurs. It's a continuum and it's almost cyclical; it goes around and around. So I think it's important however we structure the new system, however that appears; and as I say, perhaps it's having one board and then having to look eyeball to eyeball, and you have to be as accountable as I do when this woman comes with the concern.

I would say that most people would probably just have gone home and gone without the service, and I'd say the majority probably do that, so you're fortunate to know about this situation. But how do we change the system, I think is a big challenge. I think first of all there has to be a degree of trust among all providers that we're all here for the same purpose, and unfortunately that's not the way it is now.

Mrs Caplan: I'm on the verge of advising this constituent to take him home after the therapy session and then take him back the next day and, if asked, to say she has a pass. It seems so unreasonable for them to force somebody to stay in an institution who doesn't want to be there, who doesn't need to be there, in order to be able to get a service that should be available without being told, "I'm sorry to have to stay here in the institution." Can you think of anything else I can advise her to do in the meantime?

Ms Bamford: I think if it were my parent, I would probably take him or her home and try to make do without the service for a while, and either push for change and ensure that change does take place, or find an alternative way of getting at speech therapy.

Mrs Caplan: But you see, she's frightened because she's been told that if he doesn't have an hour a day for the next few weeks, his aphasia, his recovery from the stroke, may not be as good as it might be if he has this treatment, and the family is being torn. She wants him at home. She wants to take home and she wants what's best for him at the same time.

It's the inflexibility of the institution that is the barrier, how you make that more responsive as part of long-term care reform, I think, and also looking for the shift from institution to community for these kinds of services that we're trying to accomplish. I don't know if Bill 101 does it, because it only deals with how we fund nursing homes and homes for the aged; it's another whole component. But this story has just happened, and I thought if somebody had some advice—the parliamentary assistant might want to give me some advice on what to do to get this chronic care hospital to say: "It's okay for you to have a day pass everyday. Come visit us for your therapy only."

Ms Bamford: But I'm thinking of the child I referred to earlier in providing the continuum of care very cost-effectively. This parent ran into the same problem with speech therapy and ended up getting tapes from the library and teaching signing to this child herself and being very successful at it. Desperate people can often think of some very creative ways of circumventing problems. I think that's what we continually are amazed at in the community. People are very creative and innovative, as they have to be.

The Chair: Thank you very much for being creative and innovative with us this afternoon. We appreciate your remarks, and I think particularly the sort of context that you've placed them in. It's been very helpful. Thank you.

Mrs Fawcett: I have a suggestion for the ministry that maybe all of the VON chapters and branches that wish to participate in that pilot project should be allowed to do so, because then we'd get an experience from right across the whole province. I imagine with the network that they have, we would then come with the absolute, best model.

Ms Bamford: Thank you.

SOUTHWESTERN REGIONAL CENTRE AUXILIARY

The Chair: I call our next witness from the Southwestern Regional Centre Auxiliary, if you'd be good enough to come forward. Welcome to the committee. If you'd like some water, feel free.

Mrs Cunningham: Could I have a question of Mr Wessenger, please, while the delegation is getting ready?

The Chair: All right.

Mrs Cunningham: I just wonder how the public can get hold of the draft policy manuals. We've had a couple of requests here and I've just now had another one.

Mrs Caplan: Will they be available in March?

Mr Wessenger: I'll ask staff to indicate—

Mr Quirt: The first draft of the policy manual is out. It was shared with members of this committee and it's been sent to about 40 provincial organizations for comment. The second draft is due out in the next few days, in a week or so. If anyone would like to call, our office is the long-term offices in Queen's Park, long-term care division. It's in the blue pages or in the Queen's Park phone book either under the Ministry of Health or Community and Social Services. We would mail a copy of that document to whoever wished it.

Mrs Cunningham: I can advise you right now that Persons United for Self-Help wants a copy.

Mr Quirt: Why don't we just send it to PUSH. In which location?

Mrs Cunningham: Here in London.

The Chair: Thank you. Welcome to the committee, if you would please identify yourself for Hansard and then please go ahead with your presentation.

Mr John Fleming: I'm John Fleming, president of the Southwestern Regional Centre Auxiliary. If you can't hear me, I'd appreciate you letting me know, because I have one bum ear and the battery has just played out.

The Chair: We hear you very well.

Mr Fleming: Fine. The Southwestern Regional Centre is a large, self-contained institution with large, beautiful grounds, a cottage and a wooded area for a summer camp, a ball diamond, a farm with farm animals, fields of edible crops and a miniature golf course donated recently by a service club. It has its own sewage plant, and water supply drawing water from Lake Erie.

The centre was constructed a little over 25 years ago, and it is the largest employer of labour in the district. As of March 31, there are still 511 residents, 487 of whom I believe could well be considered as unsuitable for community living.

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Southwestern is recognized as a leader in innovative programs for residents. People come from all over Canada and the United States to see the programs carried on there and how efficient the staff care is for the residents. There are learning classes, including the use of computers. I might say I have a book here that lays out all the different courses they have, and there are a great many. There is a special swimming pool designed especially for handicapped people which includes a new electric lift to make it easier for residents to get in and out. Many wards are now laid out like apartments, giving a homey atmosphere, with their own kitchen facilities. Dances and other entertainment, as well as church services, are held for the residents. You will be pleasantly surprised at the interest and pleasure many severely retarded still get from music.

The centre has an apartment furnished for the parents who come from a distance to see their children. All medical facilities, including doctors, nurses, an infirmary and a dental office, and even a barber and a beauty shop, are available. There is also a cafeteria and coffee shop.

I am president of the auxiliary and I have a son who has been there as a resident almost since the institution opened. I am there frequently, and I can say nothing but nice things regarding the way the staff treat residents. With everything available in this one institution, and with so many people for the residents to meet every day, it helps keep them happy—and they are, in general, happy. I would defy anyone to prove that, except for those who are mildly retarded, community living can do as much for residents as life in these institutions, and I certainly will say one thing: They can't furnish the help required for some of these people who have to have it so quickly the way an institution can where all the services are there.

I have always been proud of the institutional system for our mentally disabled that was put together in Ontario, which is second to none. I doubt that any country was using their unfortunate people better. Yet in the last few years, government has brought in plans for closing these institutions which were built at great expense to the people of Ontario, to be replaced by community living, a much more expensive system.

As a matter of fact, according to our administrator a little more than a year ago, he claimed that it cost five times as much to keep one resident in a group home as it did in his institution. If you were to consider that that institution was designed originally for 2,000 residents, and you bring it up from the number of people who are there

now to more the size that it should be, you would cut your per diem rate a great deal. The more expensive system can never be used by a great many of these unfortunate people. This takes away the rights of many and favours the few.

I have been unable to obtain a copy of Bill 101. The government person to whom I talked was going to send me a copy, but I never received it. I couldn't get one from the institution, I couldn't get one from the town of Blenheim, and I couldn't get one from our member of Parliament, Pat Hayes. So I had to go by guess and things that I read from different federation members. But I do believe, from what I have read, that in relocating the residents, the wishes of parents or guardians have been ignored, and I consider this to be wrong. I think the parents should be consulted before any change is made.

We have had several meetings with parents in the last three years, and I have been in other institutions when parents were at the meetings. I can assure this panel that those parents wanted their children left in institutions, a system that looks after more people better and for less money. Our next board meeting will have a turnout of parents.

When community living started, many people listened to those who were pushing the new system: an excellent system, I believe, for the mildly retarded, but a system without the backup required for those mentally and physically disabled needing constant medical attention. The euphoria of the time led people to believe that anyone coming from an institution to a group home immediately improved, could learn a trade and immediately become self-supporting and capable of holding a job. Now we know differently.

With little money available for our group homes, there are few new openings, so now there is a pause when the government and members of Parliament have time to reassess the situation. I hope that this will be done and that there will be a change of thought in Ontario.

The Chair: Thank you very much for your presentation and for coming to the committee. I think you're the first one from the centres, from the auxiliaries, who has come before the committee, and we appreciate that. We'll begin the questioning with Mr Hope.

Mr Hope: Well, how are you doing, John? I know you and I have had a number of conversations on this, and I even got myself into trouble on some of the comments I've made.

Mr Fleming: Well, I'll say one thing for you: You're one member who certainly has been through that institution several times.

Mr Hope: I know that during our conversations many a time we've talked about the idea of moving services into the community, moving people into the community. You've been through the experience, with the multi-year plan, of the services supposedly being in the community and not being there, and people falling victim. I know there have been a number of studies, and I'm wondering if you can inform the committee about the transition from institution to community when we're not prepared in the community to deal with it.

Mr Fleming: Many of the residents are subject to seizures, very severe ones. There's just no way, because if they took a quick seizure you'd have to get them into a hospital, and if that hospital has a backlog, who are they going to treat first, those people from an institution for the retarded, or are they going to take what we call "normal" people first? If so, by that time they could be too late. At the present time, if anything happens up in that institution, they are immediately looked after.

Mr Hope: The other question I'd ask is, in our community, in Essex-Kent, we've seen the disabled living in nursing homes or homes for the aged or rest homes. As a comparator of what they provide in services and what the Southwestern Regional Centre has, I wonder if you can give the committee a synopsis of the difference in services that are there.

Mr Fleming: To begin with, they don't have the money to have the same type of equipment or the same type of skilled help. In some of those institutions it's very grim. There's one right near Blenheim where a lady—I believe she was a superintendent—is up on charges of abusing people. That particular home today has a mixture of retarded and psychiatric-type patients. It's pretty grim when you go there. On the other hand, they've got no place else to go. If you went through it, I'm sure you would think, "Thank the Lord I'm not there."

Mr Jamison: Thank you for your presentation. I just have a comment to make. In my area we have the Association for Community Living, in Norfolk and Simcoe. I had the opportunity to visit, with the minister, a number of locations within our community where in fact people had gone from their institutional setting at Le Manoir to live, and it was made clear to us that the expense, at that point, certainly—we've been well into this in Norfolk for some period of time. This institution is now being phased out as much as possible, and I understand there is some goodly concern about levels of disability and so on.

But the two homes that I visited just recently—I'll give you one example. There were three people living there. Two of them had part-time jobs, and they were absolutely delighted that they were now contributing, that they were actually paying taxes. Imagine that: someone happy to be paying taxes. So I'm not sure that I agree that we should carry on the way we have been. The community living approach is a different venture and certainly it's something that has to be closely scrutinized, but in my opinion, from what I have seen in my own area, I believe that there are some very good benefits to the people involved there. I've seen it first hand.

Mr Fleming: I believe in that for the mildly retarded, and that sure, they can learn to hold a job.

Mr Jamison: Some of the people I saw were—well, it depends on what you would classify as being mildly retarded.

Mr Fleming: That's true.

Mr Jamison: Some of the people I saw functioning very well were not just mildly retarded.

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Mr Fleming: We also get back to dollars and cents, because if you have three people there and you're going to handle them right, you've got to have staff on 24 hours a day. That's a pretty expensive deal. When they started to open up the community homes, the ideal number was supposed to be 14 residents. Then it kept cutting down and cutting down.

I was over at one in Chatham because one of my son's friends is in that institution. My boy had a birthday on Sunday, so I'm picking the other boy up and my boy and he are going to the show and to a restaurant on Saturday night. In that home, they bought a duplex: three on each side. It means two staffs. If they can knock a hole in the wall, they can cut it down and have one staff, but that's not the way it's done.

Mr Jamison: Just to finish off, the indication I received through the minister and the minister's staff was that it was less expensive in most circumstances to provide the services that way, and it seemed to be more beneficial to the individual.

Mrs Fawcett: I appreciate your coming today. I'm not familiar with this centre, but certainly from what you have said in your remarks it does sound like a very good centre. I think we all agree that the choice of people, the choice of families, is very, very important. Have there been residents from this facility moved out into the public already?

Mr Fleming: Definitely. As I say, I'm going to pick up one of them on Saturday night who is in a group home in Chatham.

Mrs Fawcett: Do you have any reports or can you tell us whether you think it's working?

Mr Fleming: Well, he's not doing badly, but it depends on the degree of retardation. My son's learning power, for example, is caught at age six. I don't care how smart somebody running a group home is; they can't change that. Nobody can change that except the good Lord. My boy is also crippled. If he stands up for any length of time, he wilts right down to the ground within five minutes.

They were going to put him in a group home in Chatham. At the time, they were going to do over the old Holiday Inn and put him and another boy in one unit. What for? He couldn't do anything. Where is he further ahead, to be cooped up in a residence with two or three for the day, or out there where he meets several hundred people?

The boy that he was being put in the place with would have very violent seizures. They never knew when he was going to have them, so they put one of these crash helmets like they use on a motorcycle on him so he wouldn't split his head. But I could just imagine him and my son being together. The boy falls down on the terrazzo floor and splits his head open. By the time my son, who's about one mile an hour, ever got to the telephone, which he couldn't use, or he got hold of somebody to get some help for that boy, that boy would be dead.

Mrs Fawcett: I suppose we would hope that all of that would be taken into consideration when the placement of these people out in the community—

Mr Fleming: It certainly was a consideration to me, because I made sure my boy didn't get out.

Mrs Fawcett: Of course, and I think all of those things have to be taken into consideration. I appreciated your personal experiences being told.

The Chair: Thank you very much for-

Mrs Cunningham: Can I just-

The Chair: Yes. I'm sorry.

Mrs Cunningham: No, it's all right. I just wondered if you were going to let me here.

Mr Fleming, there are so many people who really admire the work you do with regard to Southwestern Regional Centre, not just for your own son but for the other residents.

I too am a mother of a special young man who has seizures and who can't be on his own. We've been fortunate, to this time, to be able to keep him in our home. His injury was the result of a car accident, so we have help that we were able to get through litigation, and that's how I spend my time. I can tell you that anybody who doesn't listen to parents when it comes to the best care for their children is a person who doesn't know very much about the world. So I'm really glad that you came here today. I'm thinking that your message is probably that we need a little bit of everything when it comes to caring for people.

Mr Fleming: Yes. I'm not trying to knock community living for everybody.

Mrs Cunningham: No, but you're saying that if we are going to deinstitutionalize many of our citizens, we have to have good services in place.

Mr Fleming: Right.

Mrs Cunningham: You're also admitting that there are a lot who never will be able to be deinstitutionalized—they just won't be able to be—and there are community outreach programs for people who are in institutions, and they do get out of the institutions and they do other things with their lives, but heavily supervised.

Mr Fleming: I refer to my son as my boy, but he's 37.

Mrs Cunningham: They'll always be our boys. I must say, though, that I have other children in my family too, and I refer to them, even more so than to Kevin, as "my boy," because I don't think they're as mature as he is from time to time, but that's in more of a fun way. They certainly keep some of the local establishments busy. Mrs Caplan and I enjoyed their company at a very important place in London last night called Joe Kool's. So everybody has different ways of spending their lives.

I just want to say thanks for the work you do, because there are so many parents who don't have either the energy or maybe the support system we need to do the work we do on behalf of special children. I am glad you came today to let the committee members know. I'm not being political. I don't think enough people know that parents do know what's best.

Mr Fleming: We have several London boys in the Southwestern Regional Centre. As a matter of fact, one of my son's friends who is in a wheelchair and is in the same ward as him is from London, really a great boy, and the boy I am picking up from a group home in Chatham on Saturday is a London resident.

Mrs Cunningham: There are lots. There are many in our sheltered workshop. Unfortunately, that budget has been cut, and so you can imagine how busy I am to reinstate that funding. But again, thank you.

Mr Hope: John, invite them to a Saturday night dance so they get the true feeling of what it's like.

Mr Fleming: Yes, because the roof really comes off the building then. They really enjoy it. The degree of retardation doesn't matter. They wheel them down there in wheelchairs and help them every way they can to get them there. They still have some rhythm in their bodies in some places.

The Acting Chair (Mrs Joan Fawcett): One minute. I'm timing you.

Mrs Caplan: I just want to make the point that as technology is changing, and it has changed so rapidly over the last few years, there are many people, both adults and children, who have been forced to be in institutions because of their disabilities who now have that opportunity to have the choice. I think part of what long-term care reform is about is to make sure they and their families understand that this choice is available. I'll give one example, and that's people on ventilators today being able to be out in the community and not having to be in a home.

We've heard a lot of concern about choice and flexibility with this legislation. It would be my hope that it would remain as flexible as possible so that the choices that become available in the future, as new technologies change, allow those with physical and emotional and mental and psychological disabilities to have as many choices that the new advances will allow, that they are at least considered an option for them, that they are able to participate in the decisions that are going to affect their quality of life and that they also be allowed to take some of the risks that are inherent with some of those choices. That's what dignity is all about. I just wanted to make that point.

The Acting Chair: Thank you, Mrs Caplan. We appreciate that.

We really appreciate your coming today and putting this on the record. It's very important to us.

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ST JOSEPH'S HEALTH CENTRE OF SARNIA

The Acting Chair: The next group is St Joseph's Health Centre. I believe the representatives are here, if you would come forward. I would appreciate it if you would identify yourselves and then begin your presentation.

Mr Paul Dusten: Thank you, Madam Chair. We appreciate the opportunity to present before this committee today. My name is Paul Dusten. I'm assistant executive director of St Joseph's Health Centre of Sarnia, and I'm joined this afternoon by Wendy Miller, director of nursing, continuing care in St Joseph's Health Centre.

St Joseph's Health Centre of Sarnia is a 317-bed community hospital offering both acute care and chronic care services. We are one of three hospitals located within the catchment area of Lambton county. As part of a mutual agreement reached between the three hospitals and with the support of the district health council, St Joseph's Health Centre is responsible for all chronic care beds operating within the city of Sarnia. This currently represents 160 beds. A new, modern chronic care facility operating as part of St Joseph's Health Centre was constructed and opened in October 1990.

This strategic move to concentrate the provision of chronic care services from one primary centre has allowed us to develop the skills, services and expertise best suited to the specialized needs of those patients requiring chronic care. We support an interdisciplinary approach which includes appropriate medical intervention, skilled nursing and a broad range of rehabilitation and recreation services.

Our approach goes beyond the provision of institutional care. We are a link between the acute care, nursing home, homes for the aged and community-based services which exist in our community. We now operate an active day hospital which supports and fosters independent living and reintroduction of the patient back into the community.

Through our specialized skills in identifying and meeting the unique and individual needs of chronic care patients, we strive to prevent a one-style-fits-all institutional model that creates ghettos of underserviced patients.

To operate effectively, we work in harmony with other long-term care providers in our community. There presently exists a high level of cooperation, ensuring a continuum of care within the county. Also, we operate what we believe to be a unique process by including on our continuing care admission and discharge committee representatives from St Joseph's Health Centre, the medical director of continuing care, nursing, social work, rehabilitation services, Samia General Hospital, community physicians, placement coordination services coordinator, Lambton psychogeriatric consultation services—on request by invitation—and others as may benefit the work of the committee.

It is with this linkage and continuity in mind that we question the advisability of proceeding with Bill 101. We find that Bill 101 only addresses a small portion of the long-term care issues which challenge us, and most notably does not include any reference to chronic care.

Our belief, quite obviously, is that chronic care is an integral and critical part of any long-term care model, and we would encourage the ministry to await the important directions and discussions which will be generated by the release of the long-term care policy framework and chronic care role study before embarking on Bill 101 in isolation. A piecemeal approach leaves open many questions and creates confusion in areas such as continuity and quality of care, funding and governance.

I speak first re continuous quality improvement. Our hospital was one of the first to adopt CQI, recognizing its benefits over a strict quality assurance and inspection model as proposed in Bill 101. In addition, our hospital, along with hundreds of others, as well as nursing homes

and homes for the aged, already participates in a voluntary accreditation process, a process which has been developed and refined with the commitment and dedication of those involved in the provision of long-term care services.

The bill proposes yet another process, and in the absence of the information yet to be outlined in the chronic care role study, one wonders whether long-term care patients may be subjected to as many as three separate standards of care: one for acute care needs, another for chronic care and yet still another for nursing home or home for the aged care.

In governance, we believe that a continuum of care is best served with governing boards based on voluntary involvement, with the accountability and flexibility to work best in harmony with other long-term care providers in their community, presumably through district health councils and not in isolation or tied to service agreements which may be in conflict with actual needs and opportunities which may present themselves.

The bill also proposes changes in funding and payments. At present, chronic care services provided at St Joseph's Health Centre are funded through the hospital's global budget and copayments paid by the patients or their representatives. With the introduction of the copayment system, an important step was taken towards providing uniformity in long-term care funding mechanisms. Prior to this, with the absence of the copayment, patients with limited ability to pay preferred, and were probably directed, toward chronic care designation.

We would welcome any system which would continue to provide uniformity and equality in the funding and/or payment systems. However, in the absence of information pertaining to chronic care, it is difficult to assess the potential impact of Bill 101 in this regard.

I will now have Mrs Miller say a few words.

Mrs Wendy Miller: I'd like to direct you to the role of the hospital in Bill 101, particularly the acute care hospital with the long-term or chronic care beds.

The one consistent agreement among key players is the real support for reform and an eagerness to participate in the reform process. Participants eagerly await a coherent and carefully designed system for long-term care that allows people to live in dignity, both in their community and appropriate institutions.

Chronic care has changed dramatically in the last decade. To be truly comprehensive, chronic care must meet the needs of all ages and must fully serve all who require services. The chronic care patient is no longer identified as a client who requires basic or custodial care, in particular the elderly and people with disabilities. It is important that all stakeholders understand and address the complex needs for quality of life, rehabilitation, appropriate medical interventions, psychogeriatrics, skilled nursing, palliation and social and recreational needs provided by highly skilled interdisciplinary teams of professionals.

There are indeed reservations about the role hospitals are to play in the system. Hospitals maintain high standards of care in both acute and continuing care units and provide advocacy, opportunities for research and education for staff, health care providers, patients, families and the

community. Hospitals are recognized for their expertise in a variety of disciplines. Chronic care beds in the acute hospital sector are not merely custodians of the elderly and the disabled.

Access to facility services: A new system must identify the continuum of care and provide a smooth transition for patients to move from one level of care to another. The movement from one level of care to another must be truly integrated, accessible, affordable and fair.

The amendments, parts I, III and VII, identify the importance of a single point of access for facilities, the coordination and management of access to facility services and the acceptance of admissions pre-authorized by a designated placement coordinator.

Two key players in the continuum of care are not identified, the chronic hospital and the acute hospital with chronic beds, neither does the amendment address the fluid movement of placement to a higher level of care and vice versa. There are no considerations for ethnic, linguistic, religious or geographic preferences. This is not a homogeneous population.

Under placement coordination, the ministry will identify placement coordinators, determine eligibility in accordance with set criteria, determine priority for admission and manage waiting lists. This does not describe a system for placement based on communication, health and social service needs, one that is accountable and dynamic. The client requires the right care at the right time and at the right place.

There is no evidence that the prospective client is reviewed by an interdisciplinary team or a committee with consumer-advocacy participation. Who will the placement coordinators be? How will the services be delivered? Whom will they service? There seems to be much prescribed regulation.

Placement coordination services have roots in many communities. What is wrong with the present system? The focus should be to build a system on the strengths of the old with a minimum of bureaucratic procedures. The reform should be based on enhancing services and not creating new layers of bureaucracy.

There need to be mechanisms in place for updated reviews and appeal procedures that are accessible and non-threatening. There needs to be a consistent drive towards open communication and effective partnership in the management of waiting lists. The appeal board must be accessible to the consumer. The power of the appeal board is astounding. An appeal board with a quorum of one does not describe an equitable system.

It is unclear where the patient is located while waiting for placement in the institution designated by the placement coordinator. The informal care giver perhaps is no longer able to provide care and may be encouraged or desperate enough to seek admission of the patient to acute care, thus taxing a system that has already experienced the reduction of beds.

1630

Geriatric assessment units: This is an opportune time for the ministry to identify the implementation of geriatric assessment units in hospitals. Hospitals provide a tremendous concentration of human and technical resources. Objectives for geriatric assessment units are as follows:

- (1) To comprehensively assess the health of referred patients both with a traditional disease-oriented model and a functional model.
- (2) To provide short-term medical treatment, to include physical, psychosocial and rehabilitation.
- (3) To identify service needs required to ameliorate functional and social support problems, and to arrange appropriate referral to community-based resources.
- (4) To maintain the patient in the community as long as possible at the highest level of independence appropriate to the individual's ability to function.
- (5) To reduce burden of care on the family and signifi-
- (6) To assist in the identification of often reversible mental and physical disorders.

The idea of chronic care step-down units: Many long-stay patients in acute care are typically elderly recovering from life-threatening crises or critically ill with chronic problems. Many of the patients occupy beds in ICU or cardiac care units. Their condition does not warrant an ICU bed, yet they are too ill to be released to a unit bed. The establishment of a chronic care step-down unit would alleviate some of these problems. The step-down units should develop a strong geriatric focus that identifies discharge and rehabilitation plans unique to the population they serve.

Eligibility: What designates eligibility? The Alberta assessment classification system is a system that drives chronic care back into custodial care. This is a model to foster dependence. The tool does not identify medical interventions, psychosocial needs, rehabilitation, continence programs, skilled nursing care, special skin care or equipment. There is no evidence of psychogeriatric, patient-family teaching, quality of life or specialized programs. The tool is designed for payment for care only.

The transient family needs have not been identified in the placement of patients. Many families relocate due to company transfers and economic necessities, and wish to relocate their institutionalized family member. Will this be a determination for priority for admission or recognized if the person is out-of-province?

The act addresses suspensions of admissions to a home if the home demonstrates a pattern of returning admissions that would be in violation of the regulations. This is a punitive relationship, not one of collaboration. I am curious as to the location of patients awaiting placement. Waiting time would be extended due to the suspended admissions and lack of available beds. Will this impact once again on acute care beds?

Amendments I, III and VII identify enhanced accountability in long-term care facilities, empowering the province to withhold payments if the home is in breach of the service agreement. This system does not support a high level of public confidence when the language encompasses words such as freeze admissions, suspend or revoke approval to operate, and withhold payments.

Will there be a limit on the number of times admissions will be frozen due to breaches of the act before an

institution is closed or ordered to implement corrective action? Will advisory boards, advocacy committees or residents' councils be established to demand or monitor the accountability of this institution?

Again, this punitive action does not foster public confidence or establish mechanisms for ongoing accountability prior to such extreme action. This accountability format will ensure negative attitudes and stress within a community.

The act addresses plan of care. The act addresses accountability for plan of care. It states that the province will be empowered to make rules respecting plans of care. There is no indication of recognition of the interdisciplinary team that would identify a genuine holistic approach to long-term care. There is no evidence of human and technical resources or the network of health and social service providers that would contribute to an integrated plan of care. The act does not identify standards of practice that are already in place, such as the College of Nurses' that identifies the expectation that its members establish a plan of care that identifies and implements the nursing process. As well, the Gerontological Nurses' Association has developed standards of care for geriatric patients.

Available information: The enhanced accountability requires the institution to make available information about finances, staffing and operation of the home. The information does not support the development of an informed opinion. It is difficult to assimilate and make informed opinions when there is no substantiating information on the licence of the institution, the licence of the care giver, educational backgrounds, job descriptions and union contracts.

The desired procedure for complaints regarding operation of the home, conduct of staff and treatment or care should be addressed via a residents' council or a volunteer advisory board with independent, objective advocates to speak for patients and families. To be able to present conflict situations, there should be a mechanism for patients and families to meet with a spokesperson prior to the discussion of their concerns.

Inspectors: Tools for measuring, monitoring and evaluating quality of care address the powers of inspectors. What are the criteria for the inspector? Will they have a geriatric background and broad knowledge of health care programs? Where are the programs for total quality management or continuous quality improvement that involves all levels of staff participation?

The inspection process, again, is so punitive. How do you evaluate care? Would it involve identification of programs that are in place to provide recreation, counselling, education, rehab and dental services, patient and family interventions?

The inspector would have the right to question staff. The wording within the power of the inspector is not reassuring. This is not a collaborative approach. In a small community it would be very risky to complain about your employer or the institution you are inhabiting.

In today's culture, there is a movement towards decentralized decision-making, continuous quality improvement, consumerism, client advocacy and care giver accountability. These thrusts, as well as approaches used

by professional bodies and accreditation agencies, encourage adherence to standards of patient care, but through a more consultative, participative approach rather than an inspection mode.

Where are the mechanisms for monitoring the requirements for staff education and participation along with patients and families for the operation of the institution? Will legislation demand accountability for comfort allowances? Who will monitor and ensure that comfort allowances are spent on dental care, clothing or appropriate seating?

In conclusion, Bill 101 sets up a scheme for an adversarial relationship between all the key players. Ontario's diverse population is clearly reflected in client groups that we serve and the people with whom we work. There must be communication and full partnership in the reform process. There must be a comprehensive service continuum that bridges both acute and long-term care. There must be a linkage between levels of care, access to other services, flexibility in planning and innovative creativity that addresses fiscal responsibility. The system must be accountable and must function as an integral part of a continuum of services that encompasses continuous quality improvement, quality of life, and care that is based on ongoing research, education, evaluation and advocacy.

As I stated previously, there is agreement and support for changes in the system. I thank you for this opportunity to address pertinent issues of Bill 101 that I feel have had a negative effect on our patients and the acute care hospital system.

The Chair: Thank you very much for a very full presentation. I think specifically on the chronic care side, as you know, there has been reference to that, and that in March as well, I believe it is, the chronic care role study is to come out.

We'll move to questions. Mr O'Connor.

Mr O'Connor: I listened quite attentively. You presented a lot of issues. As we have travelled across the province, of course, we've heard some of these raised before, because we've had the opportunity to hear them. Sometimes you haven't had an opportunity to hear some of the responses, but we always, of course—the intent is to go around to listen and to try to improve the legislation. Of course, we've heard that it does sound somewhat bureaucratic and, I guess, in legislation it seems that way because we have our fine bureaucrats and our lawyers who developed this for us to make sure that everything is covered, and sometimes it doesn't sound quite as user-friendly as it could be.

I know that you are somewhat concerned about the plan of care. In the bottom line there, it says that the College of Nurses has identified expectations that its members establish a plan of care that identifies and implements the nursing process, and, as well, that the Gerontological Nurses' Association develops standards for health care of geriatric patients. For your information, the draft document of the manual that had included discussion around a plan of care was circulated throughout the province. Those two associations were involved in that consultation. So I guess somebody in the ministry agreed with you, and

they were involved in that discussion. So it's something where sometimes if we can share a little information, we can try to help that comfort level.

1640

I guess in question, again, we're trying to look at things that will be as flexible for the consumer as possible, and we've heard about the appeal board and the question around the quorum. I know that trying to make things as friendly as possible and as accessible as possible—when you're 85 or 90 years old, you don't want to be having to wait for months—

Mrs Miller: It's difficult.

Mr O'Connor: —while you manage to get through an appeal process.

A concern I might have is that if we get too bureaucratic and develop a quorum of three or five in trying to draw those people in so that that client, that consumer, has a chance to have that appeal heard, sometimes we make things too bureaucratic. In the legislation we talk about a quorum of one, and I guess that's similar to a lot of judicial-type hearings that take place now. So I just thought maybe I'd like you to expand on your thoughts around the quorum, because we want to try to keep it as friendly as possible and as accessible to the consumers, and I think that if we do get too big with it, we may run into problems as well and not be as accessible. Maybe you can share some of your thoughts around that.

Mrs Miller: Well, I think probably it should be reflected back into how the patient is assessed to get into the institution in the first place. I think that is where it should start. I think you should have an interdisciplinary team, because I think you have to look at all facets of the patient, and this board where the people apply for placement into a home or chronic care, wherever they would like to go, could also be the appeal board. They could go back and say, "I was refused admission, and now I'd like you to explain to me why."

On our own admission discharge committee, we do have that process in place. We have a process where our medical director sends a letter to the physician and says why the person was denied admission to our institution, because obviously they didn't fit our level of care. But there certainly is an appeal, and we would encourage you to reapply and maybe update your information. We try to make it open.

Mr O'Connor: I guess one thing that we have heard from placement coordinators' services that are present right now—and there is one in—

Mrs Miller: This placement coordination service person sits on our admission and discharge committee, as well as representation from the other hospital.

Mr O'Connor: We heard from someone today, did we not?

Mrs Miller: Yes, you did.

Mr O'Connor: My thoughts are, then, as you say, let's not get too bureaucratic. By dovetailing present systems that we have in place, should we then perhaps eliminate the need for appeals? But in that very extreme

case, should there be the need for an appeal, it would be enshrined, because sometimes we have to take a look at that extreme case, that there may be an example.

Mrs Miller: I think there always has to be an opportunity for appeal. You can't be just so cut and dried that: "Yes, you are. No, you're not. This is where you're going." As I stated before, if the process was one, your process of admission was also your process of appeal—

Mr O'Connor: Thank you.

Mr Jim Wilson: Thank you for your presentation. Yes, the appeal process is important, but have you had an opportunity to review the eligibility criteria as outlined in the policy manual?

Mrs Miller: I've not seen the policy manual, unless you're referring to the Alberta assessment tool. No, I've not seen the policy manual.

Mr Jim Wilson: I think we should ensure that these presenters also receive a copy of the draft manual, because it's fine to talk about appeals, but wait till you see the eligibility criteria.

Mrs Miller: Okay. Where would we have got this? How would we have known it was available?

Mr Jim Wilson: The government has been responsive, but I'll tell you that when we started the first week of hearings, I didn't even know this thing existed other than that somebody had given me a few photocopied pages out of it, sort of under a whistle-blowing attempt. Then the minister did authorize that the manual be circulated to all members, so you can now get one. It's not available at the local bookstore, but I think Mr Quirt will ensure that you get one. He's very good about that.

Mrs Miller: Thank you. I appreciate that. That would be great.

Mr Jim Wilson: Really, I don't think any of us on the committee has been involved in continuous quality improvement programs. At least, maybe some have in the health care setting; I don't know. Larry might have been.

Mr O'Connor: Sure.

Mr Jim Wilson: The language of the act speaks to quality assurance programs. Can you tell us the difference, and why it's so important that we perhaps amend the wording of this act to ensure that we have continuous quality improvement programs?

Mr Dusten: I think that CQI is a broader term, perhaps, in that quality assurance is known to us as more of an inspection model, one of determining what is in place and whether or not it's being done consistently. I think CQI is more one of what needs to be in place to meet the needs of the clients or the customers and getting involvement of them in the process, looking at internal processes and procedures to make sure we're constantly improving upon what exists and doing that with stakeholders in mind, as opposed to taking what already may be in place in the facility and ensuring that it's complete or done.

Mrs Miller: I could follow through with that and give you an example. I am now team leader of a demonstration project, what we're looking at is admissions to the hospital. So on our committee we have representation from health records, lab, X-ray, admitting and we have two consumers. What we're reviewing is to see how difficult is it, how much information do you need and do we give you enough information when you come? We want to make it very comfortable for you to come into our hospital and reduce your stress. That's what continuous quality improvement is. All the people involved sit down, and we consider them all our customers. I'm admitting's customer, and vice versa. Everybody is a customer, and we look to see what we can do to make it a much better situation for all the people, all the customers involved.

Mr Jim Wilson: Thank you. That's very helpful.

Could I just ask you one question? It's to do with your comments on the Alberta assessment system. I wonder if I might, through the parliamentary assistant, ask Mr Quirt to respond, because this came up last week or earlier this week. You note on the bottom of page 8 what the Alberta assessment does not do and what it does do. I wonder if we might ask, through the parliamentary assistant, Mr Quirt, to respond to that, and then I'd like to see your thoughts on that.

Mr Quirt: Yes. The Alberta assessment instrument, now the Ontario resident classification instrument, has only one purpose. That purpose is to measure the requirement for nursing and personal care so that we can distribute the resources we have available for nursing and personal care, in as fair a way as possible, to all our nursing homes and homes for the aged.

The instrument takes a snapshot of one day in time in the facility to measure the relative requirement for nursing and personal care. There may be few people away at home or there might be a couple of people in the hospital; that's fine. We simply measure the people who are there that day to determine their relative requirement for nursing and personal care.

It's not intended to measure the need of things like rehabilitation, the services of an occupational therapist, of physiotherapists, the services of a social worker, the requirement of recreation and many other important services we want to see delivered in long-term care facilities and that, for the first time, we've earmarked funding for.

Because we're using the instrument just to measure nursing and personal care does not mean we're not interested in funding and providing all those other quality-of-life programs. The instrument has nothing to do with the development of the plan of care for the resident either. I would applaud your suggestion that plans of care have to be developed in a multidisciplinary way, involving the resident and his or her family, and certainly this instrument has nothing to do with individual care planning.

Mrs Miller: I'm sorry you thought I was—all I was identifying was that it said the government would set up the plan of care. I wasn't referring back to the Alberta assessment tool.

1650

Mr Quirt: No. We're simply having a requirement of the bill that there be a plan of care. When you recognize that's a requirement of the discipline at this point, we would recommend to our facilities that they take the advice of other organizations such as the ones you've mentioned and how they develop that plan of care.

Mrs Miller: May I ask you a question? When it comes to the Alberta assessment tool, could you identify to me some of the components that identified skilled nursing care versus personal care in it? Can you think of any of the categories from A to G?

Mr Quirt: The instrument measures the services required for nursing and personal care generally. It does not differentiate between the services, necessarily, that would be required from an RN as opposed to an RNA as opposed to a health care aide. What it does is to measure the requirement for the resources of a nursing department on three levels: It measures the resources one might need to consume as a result of needing assistance with the activities of daily living; it looks at the resources from a nursing department that a resident might consume because of the behaviour that may require supervision or support from staff; it also looks at a third key indicator of resource consumption in a nursing department, that being whether a resident is continent or incontinent.

It aggregates those three areas through which clients might consume resources in a nursing department to come up with a rating or a scale from A through to G. Its job is to simply allocate funding for nursing and personal care in a way that makes each facility get its fair share of the available resources, and it replaces the system that now provides \$78 a day to a nursing home regardless of whether somebody consumes an hour and a half of care or four or five hours of care.

Mrs Miller: Yes, I realize that. Our facility went through the Alberta assessment tool in October. They were there for five days, and I sort of identified it as a good workload measurement tool.

The Chair: Thank you very much for your very detailed presentation and for coming before the committee today.

Mrs Cunningham: Mr Beer, could I ask a question that will reflect on this brief of Mr Wessenger or the staff?

The Chair: Yes.

Mrs Cunningham: In this particular brief, the presenters—and I think they're well known in their community as being very good at what they do—are telling us that governing boards based on voluntary involvement are the best form of government, and they refer there to the district health councils. I'm wondering what the role of the district health councils will be in your view. I was surprised to see them not referred to in the legislation at all, and there hasn't been a lot of talk coming from the government but there have been a lot more questions coming from the public. I'm wondering where you see them fitting in and whether they're going to be part of the regulations. I'm not saying they should or shouldn't be, but what's your intent at the moment?

Mr Quirt: The district health councils were asked on November 26 and again on December 2, by the former Minister of Health, Frances Lankin, to assume the lead role

in planning for long-term care services in each community. As you're well aware, the district health councils have a tradition of planning and providing advice to the Ministry of Health on health-related matters. In this new capacity, they'll be requested to plan for long-term care programs and give advice to both the Minister of Health and the Minister of Community and Social Services.

The Minister of Health also asked them to change the configuration of their long-term care subcommittees so that social service perspectives and consumer perspectives would be assured of being adequately represented on their subcommittee, and we are now meeting with representatives of the Association of District Health Councils of Ontario to develop a planning framework within which district health councils would discharge this new responsibility. So they'd be expected to recommend a long-term care plan to both ministers to develop strategies in their community for the creation of comprehensive multiservice agencies, which we mentioned earlier, and give the price to the government on how resources allocated to their particular area should best be spent on long-term care services.

Mrs Cunningham: What will they have to do with service agreements, if anything?

Mr Quirt: They would not have anything to do with the service agreement that's described in Bill 101. That would be a contract between the province of Ontario and the operator of the facility, whether the operator was a church or a local government or a private company. The DHCs have traditionally given advice to the government on the location of long-term care beds in their community and the requirement for them, and they would continue to do that. They would be free now to give advice on long-term care beds, whether they happen to be in a nursing home or a home for the aged. Previously, they were limited to giving advice to the Minister of Health on the nursing home program.

Mrs Cunningham: I think that since a lot of the individuals who came before the committee didn't have that information, it would be important that we get some response to what you've just said. There may be people who don't think that's a good idea, based on experiences, but I don't know; I mean persons who are involved in this whole delivery system.

Mr Dusten, Mrs Miller, if you have any observations on the responses that we got today, Γ d be most interested in hearing them. I think you should put them in writing to let us know how you feel. I certainly would have some points of view which Γ m willing to get across—

The Chair: Mrs Cunningham, there's perhaps another piece of information we could add to this.

Mrs Cunningham: Anything, so we can respond to it in some way.

Mr Quirt: Sorry, Mrs Cunningham, but I neglected to say that the decision to ask district health councils to take the lead role in planning was a decision taken as a result of the consultation on long-term care services, which involved about 75,000 people in 3,000 meetings across the province. In particular, the consumers' alliance, a group that brought together senior consumers and a number of

different consumer organizations, strongly recommended that the district health councils be given the lead role in planning long-term care.

The Chair: Thank you again for coming this afternoon and opening up a number of interesting avenues on long-term care.

VICTORIAN ORDER OF NURSES, MIDDLESEX-ELGIN BRANCH

The Chair: I would now call the representatives for the Victorian Order of Nurses, Middlesex-Elgin branch.

While they come to the table, if I could just inform members of the committee that there are two documents that have been circulated which are not being presented orally but have been presented, the brief from the Elgin County Homes for Senior Citizens and the submission from the St Joseph's Health Centre here in London. Those are provided for the information of members.

Our next presentation, as I said, is from the VON of Middlesex-Elgin. Welcome to the committee, if you would be good enough to identify yourselves for Hansard and then please go ahead with your presentation.

Ms Mary Dryden: Good afternoon. I am Mary Dryden, executive director of the Victorian Order of Nurses, Middlesex-Elgin branch, and accompanying me is Dr John Haywood-Farmer, president of the board of directors.

The Victorian Order of Nurses of Canada is a national not-for-profit, voluntary health care organization. VON understands the need to put caring first, caring through all stages of life and for the best quality of life, whether it be in the community or an institution.

The Middlesex-Elgin branch of the Victorian Order of Nurses has been in existence since 1906. The branch serves the counties of Middlesex and Elgin, with a main office in London and a satellite office in St Thomas and Strathroy. VON provides health care and home support programs. There are over 200 staff consisting of registered nurses, registered nursing assistants, health care aides, community developers and financial and clerical support staff.

The volunteer board of directors brings expertise, specific skills and commitment to the branch. The directors represent various community groups and serve as board members because of an interest in and a desire to serve the community. The responsibilities of the board are policy development, strategic planning, fund-raising and external relations.

Services and programs provided by the branch include, in the area of health care, the visiting nursing program, which offers general and high-tech nursing care, a palliative care speciality team, a maternal/newborn resource team and intravenous therapy; foot care clinics; occupational health nursing; paramedicals and long-term disability rehabilitation assessments; and shift/private duty service.

In the area of home support, the programs include the Thames Valley Placement Coordination Service; the HOMME program, helping others maintain Middlesex elders, which is a seniors home support services program; the palliative care volunteer program in Middlesex county; the Alzheimer community support program in Middlesex

county; and as of April 1, special services at home, again for Middlesex county.

The beliefs of the VON are outlined in the philosophy, which states:

- Individuals have primary responsibility for their own health.
 - The value and dignity of human life are respected.
- Access to comprehensive, compassionate family and community-centred health care is the right of all individuals regardless of their ability to pay.
- Volunteers make a valuable contribution by extending and complementing the services provided by health professionals.
 - Community services of assured quality are essential.

The goal of VON services is to promote health and independence and to enable people to live in comfort and with dignity. VON continually develops new programs and services to meet the needs of the residents in Middlesex and Elgin counties.

1700

VON's historical involvement in this community therefore necessitates that we speak to you today regarding the implications that Bill 101 will have on the health care system and the community as a whole. The concerns that we will be addressing include fragmentation of planning, consumer choice, community linkage and the appeal process.

In terms of fragmentation of planning, the legislation is a small part of the entire long-term care system, albeit an important one. The government, in moving ahead on Bill 101, has sent a message that it is still more interested in institutional care rather than developing health promotion and community care options.

Today in Ontario, the resources allocated to institutional care—ie, chronic beds, extended care beds and residential beds—far exceed resources allocated to community and in-home services. By proceeding with legislative changes for facilities before developing and publicly debating the policy framework for long-term care redirection, government is reinforcing the status quo institutional bias. By moving ahead with facility legislation outside of the long-term care policy framework and prior to local district health council planning, the government is not supporting its own direction for a strategic, policy-based approach to the health care system based on consultation.

The legislation allows for the government to designate the number of beds and to require certain types and capacity of beds for certain levels of care, service, programs etc, but does not reference these requirements in terms of any planning process provincially, regionally or locally. It would be ideal if the legislation were delayed until the policy framework is released and debated and the district health councils' planning for long-term care can be referenced in the legislation in terms of the designation of number and types of facility beds.

With respect to consumer choice, Bill 101 allows for direct funding grants to the physically challenged. It ensures consumer access to key information regarding facility services, care, accommodation and consumer knowledge of the care plan, and also allows for an appeal process regarding eligibility for service.

While supporting the incremental changes proposed to protect and increase the involvement of the consumer in his or her care, VON believes that the tone of the amendments is incremental and not comprehensive and could be interpreted as paternalistic rather than empowering.

VON recommends that consumers have a choice of whether to receive needed services in a facility or community setting within an envelope of available resources. In short, the consumer has the choice of service location.

Thames Valley placement coordination service has an excellent model, and VON supports the concept of expansion of PCS programs province-wide with the provision that the coordinators will provide the consumer or surrogate decision-maker the choice of service location. A separate brief was presented to you last night by the director of the PCS program.

With respect to community linkage, provision has not been made for consumers to move from community to institution and back to community with ease in order to meet short- or long-term needs. While there may be several agencies providing service to a client, the system can be managed to ensure that the service delivered to the client is seamless. To accomplish this, the service providers would need to look at creative ways in which to work together towards a common goal.

Regional responsibilities should include specialized service planning—that is, geriatric assessment and specialized rehabilitation resources—while local planning should include the continuum of care from health promotion through rehabilitation at all locations of service delivery: in-home, community and facility-based.

The use of a comprehensive multiservice coordinating body as proposed by the government should provide direct consumer access as well as encourage creative partnerships within and between existing community agencies. In considering options for service delivery, it should be noted that VON is broadening services to a multiservice model to better support multineed clients at home, within certain financial boundaries.

In order to ensure continuous provision to consumers of long-term care, VON recommends the proposed legislation must include a linkage of community agencies.

With respect to the appeal process, VON supports the concept of the consumer having the ability to access an appeal process for those decisions with which he or she is in disagreement.

In recognition of the consumer's right to self-determination, consumers should have an opportunity to participate in decisions affecting them. VON believes that more emphasis should be placed on the right of consumers to be a full partner in the planning for care, including choosing the delivery model and the provider best suited to meet their needs, and to be a partner in the evaluation of the services provided.

The appeal process as documented in Bill 101 does not clearly define the location or timeliness of the appeal or the financial responsibilities that may be delegated to these vulnerable individuals and their families. VON recommends that the appeal process for the client be simplified, with localized access to the appeal board.

VON recognizes the need for reform and encourages a collaborative approach to planning and implementation of an enhanced health care system which will continue to provide a quality continuum of care within the limited available resources.

Thank you for allowing VON this opportunity to present its position.

The Chair: Thank you very much, and not only for underlining a number of issues that your counterparts have made in other presentations, but I think what's particularly useful is the local setting in which all of this takes place.

I wonder if I could just, being the Chair, go forward with a question. First of all, we've heard a lot, especially in certain places, about how well the placement coordination system functions. Now, from your perspective—and indeed last night we had an excellent presentation from the director here and we had one in Thunder Bay and I believe in Windsor—can you just describe how you function within that system with the Thames Valley? Where do you come in? How do you interface with the PCS program, you know, and if you want to use an example just to help us understand how that functions.

Ms Dryden: How it fits into the organization?

The Chair: Yes.

Ms Dryden: VON is a sponsoring agent for the placement coordination service.

The Chair: So this got started in part through people coming together, and you sponsored this. Do you administer this one?

Ms Dryden: Yes, we administer the program. I believe in 1984 and 1985, when the decision was made to set up a placement coordination service in this area—the Thames Valley service provides service to three counties: Middlesex, Elgin and Oxford—apparently a tender was put forth to the community. VON was one of the agencies, institutions, that submitted a tender and was successful in securing the sponsorship and administration of the program.

The Chair: How do you determine who participates in that? I mean, in terms of administering it, do you have a board?

Ms Dryden: The VON has a board. We have a board, a group of volunteers who oversee the VON agency. The PCS program has its own advisory committee and it reports to the VON board. One of the VON board members sits on the placement coordination committee as well, but in everyday affairs, so to speak, the PCS operates very much independently and sets its policies and procedures accordingly.

The Chair: If I were a member of a long-term care agency in the community, I wouldn't necessarily be on that committee, but how might I, whether I was a nursing home or a home for the aged, have impact on the policies and approaches? Do they review procedures on an annual basis? How does it function?

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Ms Dryden: The committee itself represents the various groups in the community, like the chronic care hospitals and the nursing homes, so there are representatives from

all those areas sitting on the committee. The placement coordination staff are very active in terms of being accessible to the individual agencies and also visiting the individual agencies on a regular basis, so there's input. People technically could input through their committee of representation, and also directly on a one-to-one basis when the staff are visiting the facility, or when they're accessing service through the PCS; they could also do it that way. PCS has also circulated a number of its policies and procedures so that the agencies and institutions using PCS are aware of what the procedures are and changes and that sort of thing.

The Chair: I raise it because I think there has been a lot of interest where we have been told of one that works and works well. Other groups have tended to say, "Look, we think this does work well," but at the same time there has been the expression of a great deal of concern about the function of the placement coordinator as set out in the legislation. I think it's useful to sort of get some sense of, where it works well, why it works well. How is it organized? What does that then tell us about how this particular program ought to go forward? Because in my own area I don't think we have that function, or at least not in that way.

Thank you, Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. I just want to ask you about one sentence on the last page. It says, "In order to ensure continuous provision to consumers of long-term care, VON recommends the proposed legislation must include a linkage of community agencies."

I gather under that section, and from other comments we've had from other VON agencies, that the VON really can serve as the multiservice agency. Is that what you're telling us, and you don't want another layer brought in?

Secondly, just before you answer that, can you give us a feel for how big a job it is in your area of the province to bring together all the agencies? Because each area is different. As the Chair—his area of the province is sort of near mine, and we don't have as many services as they have in Metro, that's for sure. We all kind of know each other, and bringing us together probably isn't as big a chore.

Ms Dryden: In terms of the comprehensive multiservice delivery agencies, certainly the VON is in a position to provide that function in the long-term care reform, but not necessarily just the VON. We don't necessarily feel that it should be a monopoly in that case. There are other agencies similar to the VON that could be comprehensive multiservice agencies as well, because there are advantages and disadvantages to a monopoly type of system. Our feeling is that allowing different agencies to be multiservice agencies in the long-term care reform would then give the clients and their families a choice in what services they wanted to access for whatever reason, whereas with the monopoly, that's it. People essentially would not have a choice in this system.

Mr Jim Wilson: So what you're saying there is that the mandate of a multiservice agency include some sort of wording that would require it to ensure that it is making linkages. I'm just fishing around. I can't see us writing this into this particular bill. Maybe counsel or Mr Quirt would want to comment on this, but I can see it as forming part of the regulations or whatever. Do you know what I mean? It's a good sentence, but I don't know how it goes into legalese and how you get it into the legislation. I think that's the intent of these agencies, but whether it needs to be written in or not. I don't know.

Ms Dryden: I guess the essence of it would be that there be some collaboration rather than duplication as well, so that depending on how long-term care reform rolls out in the end, so to speak, it supports those principles of contracting with agencies that are multiservice and that can service clients from sort of beginning, early needs right through the continuum as their needs change and become more comprehensive. Then agencies that bid for being comprehensive multiservice agencies that would need some kind of enhancement to their current services would maybe look at some partnerships or working with other committee agencies, rather than duplicating those services again and creating another layer of increased costs, that sort of thing. It's easier said than done.

The Chair: Perhaps I could just ask Mr Quirt to comment on that.

Mr Quirt: Yes. Bill 101, as you know, is an act to amend a number of acts that will still be in force following the passage of Bill 101. It'll amend the Homes for the Aged and Rest Homes Act, the Charitable Institutions Act, the Nursing Homes Act and a couple of others, and it's not the vehicle through which we'd like to develop a legislative base for community programs like comprehensive multiservice agencies. So, as has been mentioned previously. it would be our intention to amend our existing acts for a while and then replace them, ideally, with a new, long-term care statute that would not only bring nursing homes and homes for the aged under one piece of legislation, but that would also provide a legislative framework for the changes that are proposed on the community side, including comprehensive multiservice agencies where they will be referenced in that bill.

We can proceed with the development of comprehensive multiservice agencies under our existing funding arrangements and existing home care program and other statutes, but it may have to fund a multiservice agency from a couple of different places for a while. But we can proceed with developing that community body without legislative reform having to precede that kind of community development.

The Chair: Mr O'Connor.

Mr O'Connor: I want to thank you for coming, because any time that we get into a discussion like we do quite often in this committee, we often find out that the information we hope would be provided to people throughout Ontario doesn't always get out there. In noticing, on page 5 of your brief, that you felt we're fragmenting planning and that the government is reinforcing the status quo in an institutional bias, in hearing that, I started looking through my notes to see exactly what the minister did say when she made a statement in the Legislature. Maybe I can just share some of what she said.

I won't read all of her comments, but she had talked about the restructuring of long-term planning capacities to ensure the inclusion of representatives of municipalities, social service planning, delivery sectors and consumers. She went on to say, "My colleagues and I believe that our new system should place the emphasis where it belongs: on community-based services that will be locally planned and delivered.

"By changing the composition of their long-term care subcommittees, district health councils will be able to assume the lead role in planning long-term care in their communities."

"Rather than continue with separate case management programs to determine eligibility and purchase service from community agencies, we will, over time and in an orderly way, integrate the functions of case management and service delivery. We will bring together existing agencies such as home care, placement coordination services and a range of service delivery agencies to create comprehensive multiservice agencies."

This is what she had stated in the Legislature. Sometimes that doesn't always get out. I went a little bit further into it because I know you've talked about that status quo in the institution and you know we're trying to make sure that all the needs are met, the whole broad spectrum within the community, and I noticed in that statement she announced \$133.5 million of the redirection budget which would be going to the integrated homemaker services in 17 program areas. I see, of course, that Elgin is one of them, and I know that Durham and York and a number of different areas have received some of that funding.

Just further on in that statement, she also went on to recognize some other needs. "To meet their needs, the government will also provide \$4.82 million an annual basis starting in 1993-94 for palliative volunteer visiting programs, for the education of more than 1,000 community-based service providers and for the establishment of 14 pain and symptom control teams." These teams will be located across the province and "will provide consultation and backup to persons delivering palliative care" within the communities. So there are a number of smaller programs, of course, that will all be part of the larger picture.

So while you come to us with your concerns that we're taking a look at—we're only dealing right now with the institutions, and I'm sure my colleagues have some concerns that way as well—we all see the need for an overall redirection in long-term care, and that will take place over a period of time.

I guess one problem with taking a look at that old Hansard, of course, I'm sure my colleagues would point out to me, is that she also stated at that time that the chronic care study would come out in the new year. So I guess we're a little bit late; we're into the new year. It'll come out this year. So there are problems when you do quote old Hansards as well and I just want to point that out, but you see where she's tried to state publicly the role of the community and the importance of it.

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Ms Dryden: I'm aware of those statements that you have made. I guess those of us who have been working in the community for any length of time and have been involved with the long-term care consultation and reform are anxious to see some of the movement in the community area and some changes that would benefit the clients of families that we're serving. We know it's coming.

Mr O'Connor: I'm glad to see that you're here and you're going to play an active part in that. I'm glad you're getting a little bit of the money to play that active part as well.

Ms Dryden: We hope to.

Mr O'Connor: Thank you for coming.

The Chair: Final question, Mr White.

Mr White: I also wanted to pick up on that issue. I share some of those same concerns. It's a huge elephant that we're moving ahead. I'm wondering, with this particular reform to the institutional care, with the placement coordination services—you know of so many of them, many of them of course being operated by the VON—would there not be more of a tendency now to find appropriate services in the community, through the placement coordination services with the VON, through those informing agents and bodies, than would have been the case prior to the PCSs being established?

Ms Dryden: Certainly, and I can speak for this placement coordination service program, that its goal and all of its interactions with its clients and families have been to help it assess the needs and identify the needs and not necessarily meet those needs with an institutional flavour. Certainly, in many cases they've referred clients and families to communities. It has essentially been one of their main goals, if at all possible, to keep them in the community setting.

In many cases they have utilized many of the community services versus maybe the client's and family's thinking that it's time now to move into an institution. With a little bit of education and referral process, they were then able to keep these people at home, where ultimately most people want to be if that's at all possible.

Certainly, in this area we've seen that change, and PCS has also used the services of the home care program. Many people have come to PCS as the first line of help and have been rerouted to the home care system as well. So it has not been just an institutional approach that PCS has had; it has been an approach to keep the client at home, if at all possible and if that's what the client wished to do. So certainly, that has increased home care's involvement and then filtered through the different programs such as VON as well.

Mr White: So although only incremental, the introduction of the PCS in this legislation does effectively move us away from an entirely institutional-based model.

Ms Dryden: That's true. It's not necessarily just institutional care that a PCS would be dealing with. They would hopefully still take the same approach, that they would assess the clients and families and help them to

meet their needs appropriately, not necessarily with an institutional base. It's true.

Mr White: Thank you, Mr Chair, for allowing me a second question.

The Chair: Thank you again for coming to the committee this afternoon and making your presentation. We appreciate it.

Ms Dryden: You're welcome. Thank you for having us.

GOLDEN YEARS ADVISORY COMMITTEE FOR SCHIZOPHRENIA

The Chair: If I might then call upon our last presenter for this afternoon, the Golden Years Advisory Committee for Schizophrenia. I believe it is Mrs Noble who is with us this afternoon. Mrs Noble, we thank you for coming. I believe you've come from Owen Sound; is that correct?

Mrs Martha Jean Noble: Yes.

The Chair: I think, if nothing else, that may give you the record for the farthest trip today. I'm not sure what the weather is like up there—

Mrs Noble: It's terrible.

The Chair: —but I know it can be tricky going back and forth. We have two documents that you have brought along. I think you can present them to us however you would like. As you know, you have half an hour and time both to present your issues and for us to ask some questions. If you would be good enough, just for Hansard, identify yourself and then begin your presentation.

Mrs Noble: Yes. I'm here on behalf of the Golden Years Advisory Committee for Schizophrenia. That is long-term care. Those are the ones who came home from anywhere from—I guess our oldest member has had her daughter for 32 years. We've had no in-home support. It's been 24 hours day in, day out for us. Those are our golden years.

I'm here on behalf of Harvey and Jean Noble. That's my husband and I. God has given us quite a load to carry. We have one daughter with chronic schizophrenia and we have one daughter with multiple sclerosis. So from all this, we feel we would like to feed back into the system whatever we can to help make life a little easier for the rest.

The Chair: Could I just ask you one question? The Golden Years Advisory Committee for Schizophrenia, is that essentially Grey county or Owen Sound?

Mrs Noble: Yes, Grey county, Bruce—we have several little families throughout Ontario that we keep in touch with. We're a kind of support for each other and we keep hoping for improvements day to day before we go to meet our Maker. That's why I'm here today, if I can help that movement along at all. It's to help us rehabilitate our siblings suffering from schizophrenia. Our table of contents is, "What is Schizophrenia, Background Information, Purpose and Goals and Objectives."

The Golden Years Advisory Committee was established in February 1991 to address the needs of families supporting the long-term mentally ill at home. Schizophrenia is not a rare disease. As far back in history as 3000 BC, scholars have found descriptions of people with similar

symptoms. Schizophrenia is not generally accepted as a product of modern civilization but one which has been with us throughout history.

Schizophrenia is a very destructive illness, most common in young people between the ages of 14 years and 28 years. Recently, research has proven again and again that schizophrenia is a biochemical disorder in the brain. As recently as 30 years ago, the diagnosis of schizophrenia often meant lengthy institutionalization. The discovery of anti-psychotic drugs, also known as neuroleptic drugs, has changed all that. Anti-psychotic drugs have enabled many people to function successfully in the community.

To have a chronically mentally ill loved one is indescribably painful. There is no illness that causes more distress or anguish than this horrible disease. The patient suffers from some or all of the following: hallucinations, delusions, loss of judgement and loss of the ability to plan and function in society. They truly try to make sense of distorted thoughts or internal voices they hear. They truly believe it is all real. People suffering from schizophrenia may have difficulty in knowing where reality ends and fantasy begins. Many people suffering from schizophrenia are highly intelligent, artistic and very sensitive. They are often rejected by friends and family, relatives and society. They do not understand the disease.

On a statistical average, two thirds of all young sons and daughters who become ill with mental disease return home to live with their families. Some 40 million families around the world know what it means to love a relative with schizophrenia. That's 40 million families, not people, and if each family consists of four members, a conservative guess, then there are 160 million people caught up in the biological disaster known as schizophrenia.

This is the background where our problem started. It started from lack of planning on discharge. Our main aim now is that we will be the last generation caught up in this horror. We understand now that there is some discharge planning going on, but it does not involve us. "We're long-term. We're long gone. We're buried. We're at home with Mom and Dad." So this is the start of it.

In the 1970s, some of the institutions for the mentally ill closed. The hospitals turned them away after a brief stay. The people were too sick for group homes. Some wandered the streets half starving, others froze to death and some were badly abused by society and the system. From the universities and colleges came some of our siblings, very ill and frightened, to share with mothers and fathers their desperate needs for survival. Like many parents, we are now senior citizens, and our sons and daughters not only suffer from schizophrenia but are socially handicapped. The need for in-home care and therapy is a very important step in encouraging the social exposure and stimulation that are necessary for the long-term sibling suffering from mental disease.

The relatives of these young victims over the years themselves often become victims of the system by trying to care for their siblings at home. However, the present system has effectively isolated these young people from the mainstream of society and our homes have become small institutions. Respite home care or attendant care, a

supportive house and supportive housing should be made available to families that are exhausted from the unrealistic expectations of the present system. We must take note of the abuse and hardship that is now apparent in senior families that have supported and cared for long-term siblings suffering from mental disease for many years. Exhaustion and unrealistic expectations breed the foundation for patient abuse.

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After many years of caring for siblings, parents are facing the concern of brain damage in our siblings. Was it caused by the disease or was it caused by the drugs? We know now that two thirds of all mentally ill young people return home to families with little or no discharge planning. I would like to just say that I was at a meeting yesterday and it is now recognized that we do have brain-damaged siblings and we have no services.

It has already been established that drugs alone are not the answer. It is the hope of the Golden Years Advisory Committee that the government will take serious note of the neglect of the long-term mentally ill. They are human beings who live in great anguish, who suffer from the pains of isolation and are rejected by society and the system. Their needs are as simple as yours and mine: the need to have friends, to be involved in the community, to worship in the church of their choice, to have supportive apartment housing; individual assessment, as some require a more structured and supervised living environment and some need to receive training, with the primary objective to return our siblings to as high as level of wellbeing as possible. Our goal is to help them to function at their maximum capacity.

The family structure and bonding is very strong in these special families. They have mourned the loss of the past, the horror of growing old and having no answers. We must be the last generation of parents to suffer the abuse of long-term neglect.

We wish to express our feelings on disability. Be it physical or mental, it should not be a factor, and to make it anything else would surely be discrimination. With the government's request for information, we wish to express our desperate needs for in-home care, in-home respite and supportive apartment housing.

In the new long-term care planning for the future, mental health appears to be preventive medicine. I mean by that that they appear to be educating people on AIDS, smoking, alcohol, and drug abuse. We would like to say at this time that we are mental disease, and there's quite a difference between mental health and mental disease. We sincerely ask that our sick young people become part of the long-term planning.

As our time grows shorter, the need becomes greater for these siblings. When the history of the past 40 years is written, we have no doubt that mental disease will produce some of the worst horror stories of all time.

We did a survey in our group as to what long-term abuse consists of in families that do not have that in-home support. This is some of what we came up with:

Our survey on long-term care giver abuse due to mental illness revealed many stress-related illnesses due to lack of

support. We found parents who were burnt out emotionally and physically; high blood pressure; ulcers; anxiety; exhaustion; many sleepless nights; depression; resentment towards the system and society; feeling trapped by fate (it is only by the grace of God that it's not you); guilt because you cannot stop the frustration and neglect.

We need:

 Respite in the home, if this is what the family needs: hourly, daily or weekly.

— In-home care to follow mentally ill patients home from the hospital to their homes. I believe they are now recognizing that as a need in some places, but that does not touch on long-term that is at home now. It looks as if we're having a hard time placing these long-term siblings at home and, as I say, we are all senior citizens.

- In-home care for chronically mentally ill patients to be provided as needed, as the majority of these siblings

live with senior citizens.

The purpose of the Golden Years Advisory Committee for Schizophrenia is to establish the needs of siblings suffering from long-term mental disease, the needs being respite care, in-home care, socialization, housing, and inheritance protection. I want to bring that up today; I think I've got a few moments here.

One out of every 100 will at some time or another suffer from schizophrenia. We do know that out of this there will be some who will have one or two attacks and then they will get over it. It will maybe be classed a nervous breakdown, exhaustion or something, and they will go back to work and never have any more problems.

We know there will be another third who will become part of the system and will need support. They will need medication. But that group will probably be able to do some part-time work and earn \$160 a month and not have family benefits touched.

Now, our people, because they have brain damage, because they are sicker—and I want to say this also pertains to handicapped people. If you cannot work, you cannot possibly earn \$160 a month. We as parents would like some type of trust set up so that we can give this extra money as a part of an inheritance to our children without touching their family benefits. It seems as if you can work and get it if you're well enough. Why, if you're sicker, should you not be able to inherit that? What difference? It would make life a lot easier for them. That's our inheritance.

To have schizophrenia removed from the mental health, to long-term care—we know it is a disease. It's a horrible disease, and until we find a home for it, we cannot accomplish too much in looking after our people, to make the government aware of the families that care for siblings suffering from mental disease and to improve the wellbeing and lifestyle of siblings suffering from long-term mental disease.

Would you like me to go on now? I have the objectives here in the back. We have carried out some of those as the Golden Years committee. Would you like me to go on with that now?

The Chair: If you wish, or we can ask questions on your presentation.

Mrs Noble: All right.

The Chair: I think your objectives are quite clear. We can read that, if that's all right.

Mrs Noble: That's fine.

The Chair: First of all, let me just say that we are very glad that you have come to the committee because you obviously have a perspective on this issue that is really very different from the ones we've been hearing. I think the observations that you have, both about parents as well as about those with schizophrenia, are very important to

We'll begin the questioning with Mr White.

Mr White: I also want to thank you for coming. This is an important perspective you bring. We're talking about a long-term care issue, really: the care for children, siblings, people who will be with us for a long time and who, as you so well point out, require respite care. Families certainly do. To support you at home really requires a range of services that just hasn't been present for you.

Mrs Noble: That's right.

Mr White: I have worked in this field to some degree in the past. My sister, as a matter of a fact, does some in-home work with families in, I think, the Bruce county area. She works out of the hospital, but she only goes to the hospital one day a week. But she visits with families in the rural areas of Bruce county. I'm wondering if you have a similar program there in Owen Sound.

Mrs Noble: We have found that when they've come home with us, if we move-and in our case we did move after we had retired and went up there-you don't fit into the system. We have found too that once you get them at home—and we do know several of our members have asked for respite—we don't get it. This is from the Grey-Bruce Regional Health Centre. They just say they don't have any beds. In fact, we have campaigned to try to get respite beds and we haven't had much luck in this. We also went to home care and pursued the thought of respite, and were getting this, "We do not have the budget for longterm care." And when we go to mental health, they say they don't have any money. So then we're told, all right, if our next-door neighbour can take in three or four mentally ill young people and this is called a licensed home, they will get \$26, \$27 a day plus \$3,000 a year respite. And we're saying we don't get any respite.

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Mr White: So there's a problem if you move to the area and your son or sibling wasn't discharged from the hospital locally, and there's also a lack of respite care in the hospitals.

Mrs Noble: Oh, there definitely is.

Mr White: Have you been involved in any community planning in regard to the very kinds of services that you are talking about? I know I was, in my area of the province: fairly extensive plans to offer community-based services such as the ones you suggest. Has there been that kind of effort in Owen Sound?

Mrs Noble: We tried, we really did, and finally we just started mailing in letters to the Ministry of Health and

to the Prime Minister. It appears that they realize that two thirds go home. That's a lot of people without a budget, you see, and someone is saying, "Well, where does the money come from?" They know it's long-term care. We're finding this. Long-term care is kind of a dead end, but it's not fair to us as families.

Mr White: It's a very sad situation, and I'm sure it has been repeated in a number of areas of our province. I only hope the best for you. Thank you for coming.

Mrs Fawcett: I want to thank you for coming. My goodness, they say the Lord gives you only what you can handle, but you must be a very, very strong person. There have been a lot of years that you have had to provide long-term care, and you-and your husband, I would assume—are the sole providers. Certainly it would seem that you're falling in between the cracks of health care. and somehow we have got to make sure that you people are included somewhere. If nothing else, respite care should be available to you, and also help for those suffering. Certainly the Friends of Schizophrenics in my area have solicited my help on numerous occasions, especially around the Advocacy Act, and I'm sure there are certain areas of that that have provided you with a few problems as well, because you can't always, even as a parent, do what you want to do.

So I really take everything that you say here very, very seriously, and we will endeavour to make sure that somehow that you get included in this. Thank you.

Mrs Noble: Thank you.

Mr Jim Wilson: Thank you, Mrs Noble. As you know, I represent the riding next to you in the Collingwood area. I wish you a safe drive back, and certainly appreciate your coming all the way to London to share your views with us.

I think you'll find that there are a lot of politicians at Queen's Park who have either family members or friends who suffer with schizophrenia—we've noticed that in other committee hearings we've had—so it isn't for lack of some high degree of understanding among politicians. It seems to be a lack of getting our acts together and getting services in place.

With that in mind, you know that this particular piece of legislation amends the Ministry of Community and Social Services Act to allow direct grant payments to individuals for the purchase of attendant care and other goods and services. It's to be done on a pilot project.

If you don't mind, I'd just like to ask the parliamentary assistant really a two-part question. What is the status of schizophrenia in terms of whether it is recognized by the government as a disability, and secondly, would people with schizophrenia qualify somehow to be included in this pilot project?

Mr Wessenger: With respect to the question of the disability, I will certainly ask staff to indicate that, because I don't know whether it's considered a disability. But with respect to the question of it being involved in the pilot project, no, as I understand it, the pilot project is related purely to physical disabilities. I think I'll just ask staff to comment on it.

Mr Quirt: The term "disability" is not a strict defining terms in terms of the pilot project, Mr Wilson. It would be better to put it that people who need personal care, or assistance with that, and people who had the ability to manage their own care would be candidates for that pilot. "People who are disabled" certainly describes it in a broader way than simply "physically disabled," and that was our intention, to describe it in a broader way than "physically disabled."

Quite frankly, I'm not as familiar with it as I should be to support the committee with respect to the government's position on services—community health services, for example—for people with schizophrenia. But I'd be happy to make a request of my colleagues in the ministry to provide you with some information on the state of services for people with schizophrenia with respect to community-based programs, with the community mental health programs and so on, and try to provide you with that early next week.

I'm not sure, quite frankly, at this point in time—I certainly wouldn't rule out someone with schizophrenia in terms of the direct funding project, but it's intended for people who would accept money from the province and purchase their own supports. I think it would depend less on the diagnosis that someone had and more on their need for personal support services of an attendantlike nature. I certainly wouldn't preclude people who were diagnosed as having schizophrenia from the pilot, but I'd have to find out more about the services that now exist for them. I'll certainly raise that issue with the committee that's now working to design the pilot project.

Mrs Noble: Could I just say at this time the majority of senior citizens are paying for our in-home help? These people, you know, become quite disorientated. There's their laundry, their personal hygiene, and it becomes a real problem for senior citizens. You get to the point where all you can do is look after yourself. The one way we got around it was that we now hire help. In our house we have six hours a week for this girl, which we pay for, so I'll leave that with you too.

Mr Jim Wilson: In your experience, is schizophrenia a very debilitating disease?

Mrs Noble: Yes, it is.

Mr Jim Wilson: I know that from firsthand experience in my own family. All committee members should take note, and I appreciate your comments, Mr Quirt, and I would appreciate the parliamentary assistant getting back to us on the points that have been raised by Mrs Noble, particularly because you'll note number four in the objectives is exactly, "Initiate a pilot project to assess the benefits of in-home care (attendant care)," so actually it would be very nice if Mrs Noble's request could fit in with this legislation. So get back to us; we'd appreciate that.

The Chair: I think Mr Quirt has a comment he wishes to make.

Mr Quirt: Just a further piece of information: Through the long-term care consultation, the need for programs that support family care givers, respite programs, for example, and other ways to help people who are perhaps not the client or the patient in the system but the people

around them who are supporting them to live independently, was a proposal in our consultation document and very strongly supported.

We intend to work with representatives from other ministries and from the community to look at ways in which care givers can be better supported, in addition to respite services. Clearly, in that case, regardless of the reason for a family having to support a member to live independently in the community, I would suspect that families having to support family members, for whatever reason, would be included in that planning. I'll also bring it to the attention of the people responsible for that project and, with your permission, provide them with a copy of your presentation here.

Mrs Noble: Thank you.

The Chair: Perhaps we might also indicate that when we have that information, we would make sure you receive a copy of that as well. I think that might be helpful to you in your own community.

Mrs Noble: It would be, yes.

The Chair: Did you have another comment you wish to make?

Mrs Noble: No, I think that's wonderful. Everyone's aware of it. I feel that I'm going home with an awareness and that's what we all started out to do, to make the government aware of the injustice of it. Do you know that when we were married 45 years, we had to put this girl in the hospital for a month in order for us to have a holiday? The standard thing is that one goes away for holiday and one stays at home. It's a very crippling thing in a family. The family cannot function.

I look back on my life and I know that we have been deprived of a lot of good, healthy living because we've always had to put her first. Mind you, she was in her last semester of accounting when she came home, so she is well educated but she's had a lot of brain damage.

We've got a housing project going now and this in-home care and what not is very important. If we can get the in-home care, this means we can do the supportive housing, the little apartments where they can do their own thing, you see, which we think is probably the answer. Thank you.

The Chair: Thank you. I think if there's been awareness raised it's been here on our side. we're very appreciative that you took the time to come. Hopefully, we'll be

able to address the kinds of issues you've raised a lot more effectively in the future because of it.

Mrs Noble: Thank you. You know, my daughter with multiple sclerosis is now in palliative care. She's had MS since she was 15. She's 46 now, so in the long-term planning we know we won't have her too long. However, from it all we hope that something good will come. I just sat and I put it down the best I could for you.

We are greatly concerned and saddened that young disabled adults, through no choice of their own, become victims when the time comes that total care is required. I would just like to say it's not just MS. We've got accident victims too. In a farming area there's snowmobiling and there are all kinds of things.

The choice of facilities in Grey and Bruce counties is very limited. Long-term care is now filled with the very old and frail requiring total care. The environment is doom and gloom of the soon to die.

At this time of planning, we would like to suggest that a designated unit centre for young, physically disabled total care people be established at the Grey and Bruce regional centre. I must say that in order to get that unit, we have to go to Kitchener or London. I think there's enough of a population within the area that it would be well received.

The unit would greatly enhance their lifestyle, ensuring them of dignity and fulfilment. At the present time there is adequate space and equipment and there are several internists on staff at the Grey-Bruce Regional Health Centre, making this project very cost-efficient and beneficial to the young, total care adult.

As parents, we sincerely ask that you consider the very real need of these young people to be allowed to die with as much dignity as possible.

The population of Grey and Bruce is 150,000 and, as I said, the Grey-Bruce Regional Health Centre has adequate space and sufficient equipment. With everything being made smaller, we have the space. Several doctors—and there are internists there—are already employed. The cost of establishing this unit would be a minimal cost to the taxpayer and a great benefit to total care. Thank you again. I want to thank you all.

The Chair: Thank you for that, and certainly putting that in Hansard will make sure it gets back through the parliamentary assistant to the minister.

The committee now stands adjourned until 9 o'clock Monday morning in Sudbury.

The committee adjourned at 1755.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

*Chair / Président: Beer, Charles (York North/-Nord L)
Vice-Chair / Vice-Président: Daigeler, Hans (Nepean L)

*Acting Chair / Président supplement: Fawcett, Joan M. (Northumberland L.)

Drainville, Dennis (Victoria-Haliburton ND)

Martin, Tony (Sault Ste Marie ND)

Mathyssen, Irene (Middlesex ND)

*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

*White, Drummond (Durham Centre ND)

Wilson, Gary (Kingston and The Islands/Kingston et Les Îles ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

Witmer, Elizabeth (Waterloo North/-Nord PC)

*In attendance / présents

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Oriole L) for Mr Daigeler

Carter, Jenny (Peterborough ND) for Mrs Mathyssen

Hope, Randy R. (Chatham-Kent ND) for Mr Drainville

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer Jamison, Norm (Norfolk ND) for Mr Gary Wilson

O'Connor, Larry (Durham-York ND) for Mr Owens

Wessenger, Paul (Simcoe Centre ND) for Mr Martin

Also taking part / Autres participants et participantes:

Cunningham, Dianne (London North/-Nord PC)

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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Saint Luke's Place
Don Attridge, president, tenants' association
John Kauffman, administrator
We Care Homehealth Services
Jeff Hitchcock, owner-operator
Ronald G. Hoppe, representative
Ontario Association of Non-Profit Homes and Services for Seniors
Robert Pettitt, chair, community and government relations committee, region 3
St Joseph's Hospital and Home
Brian Ayer, trustee
Sister Margaret Myatt, president and chief executive officer
David Rudy, vice-president and administrator
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Golden Years Advisory Committee for Schizophrenia
Martha Jean Noble representative





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Second Intersession, 35th Parliament

Official Report of Debates (Hansard)

Monday 22 February 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Assemblée législative de l'Ontario

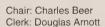
Deuxième intersession, 35^e législature

Journal des débats (Hansard)

Lundi 22 février 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée





Président : Charles Beer Greffier : Douglas Arnott

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 22 February 1993

The committee met at 0908 in the Northbury Hotel, Sudbury.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. I call the meeting of the standing committee on social development to order. We're glad to be here in Sudbury. There were moments last night when we weren't sure we were going to get out of Toronto, but here we are and we're very pleased to be here to begin a day of hearings on Bill 101, An Act to amend certain Acts concerning Long Term Care.

REGIONAL MUNICIPALITY OF SUDBURY HEALTH AND SOCIAL SERVICES COMMITTEE

The Chair: Our first presentation will be made by the regional municipality of Sudbury health and social services committee, if the representatives would be good enough to come forward and make themselves comfortable. If you'd be good enough to introduce yourselves to the committee and for Hansard, and then please go ahead with your presentation. Could I just say to people, don't touch the mikes or you'll self-destruct, and we wouldn't want that to happen.

Ms Mila Wong: Good morning. We'd like to welcome you to Sudbury. My name is Mila Wong and I'm the vice-chair of the health and social services committee for the regional municipality of Sudbury.

Mr Mark Mieto: My name is Mark Mieto and I'm the regional director of health and social services for the regional municipality of Sudbury.

Ms Wong: We're very pleased that the standing committee on social development is allowing different municipalities, different stakeholders, to participate in this process, and I guess in the true spirit of democracy, we wish to be heard.

Today, my presentation will cover the following topics: client choice, involvement of the home, medical director's involvement, monetary issues and operation of residential services. To facilitate notetaking, we will be able to provide you a copy of our presentation today.

Under client choice, the current act states that a choice of accommodation in the long-term redirection was always addressed as the client's right to choose. It states: "Any person who is over the age of 60 years or...because of special circumstances...cannot be cared

for adequately elsewhere...is eligible for admission...[and] may be admitted."

There is a promotion of racial equality and respect for cultural diversity. Services take into account people's different values, religions, languages and customs. This is stated in the discussion paper on long-term reform. However, Bill 101 as written does not recognize the importance of the contributions of these groups that they provide in the delivery of care to seniors.

Under the current act, primacy of the individual and the right to dignity, security and self-determination are responded to. Seniors do not wish to sacrifice their individuality or dignity, and we affirm their right to participate in determining what services they require and how they are provided. However, under Bill 101, the suggested new roles for and the power of placement coordination services could very well undermine the rights of long-term care residents.

Bill 101 states: "A person may be admitted to an approved charitable home for the aged only if (a) a placement coordinator has determined that the person is eligible for admission...and (b) the placement coordinator designated for the home...has authorized the admission of the person to the home."

The proposed section 9.5 designates great power to the placement coordinators to determine if and where a senior may be placed. That is one of our biggest concerns. The rights of the seniors are not acknowledged. The bill does not grant applicants any say in the determination of which home they may be admitted. Only the placement coordinators have this power.

Regarding the appeal process, the right of the applicant to have a say in the placement does not occur prior to the placement, only after placement coordinators have their decision, and then their only avenue is through an appeal process.

The terms of reference for an appeal are limited to simply appealing the placement coordinator's rejection of their application. It states: "An applicant for admission...who is served with a notice of determination of ineligibility...is entitled to a hearing by" an appeal process. We're saying that if this is the only reason why they can appeal, you're actually stressing people who don't want to stay in that specific home.

We recommend that the legislation should be amended to clearly provide for the consumers (a) the option to make direct application to a facility of their choice; (b) the appeal mechanism in section 9.7 should be expeditious with a minimum time period of 30 days. Furthermore, there are no grounds specified in Bill 101 for the consumer to appeal other than if their application is rejected. The rights of appeal should include language, custom, religion and also respecting cultural diversity.

The next sector is home involvement. Under the current act, the homes are responsible for safe and competent care of the residents. The homes should have access to information regarding the applicant's health status to ensure appropriate care can be given. The current regulation does require the director's involvement in the admission of applicants. It states: "An administrator...shall admit persons to the home in accordance with section 18 of the act and with this regulation."

However, Bill 101 does not identify the director as one of the persons involved in authorizing the admission of a person to their home. Bill 101 states: "A placement coordinator...shall determine in accordance with the regulations whether to authorize the person's admission to the home." Consequently, the homes would have great difficulty maintaining safe and competent care for the residents if they are receiving new residents whose needs and health profiles are unknown.

Under the current act, the director is responsible for the programs in the home. It states: "An administrator...shall organize a continuing program of varied and meaningful activities designed to stimulate the interests of the residents including continuous learning, activation programs...recreation and entertainment, handicrafts...in such a way to enhance the residents' lifestyle," and further, "shall allocate proper accommodation to residents taking into consideration the type of care needed."

Section 9.12 of Bill 101 requires the homes to develop their own plans of care. It states: The "home for the aged shall ensure that...a plan of care is developed for each resident to meet the resident's requirements," and "the plan of care is revised as necessary when the resident's requirements change," and "the care outlined in the plan of care is provided to the resident."

Furthermore, section 9.13 of the bill requires the homes to develop a quality assurance plan: A "home for the aged shall ensure that a quality assurance plan is developed and implemented for the home...for monitoring the quality of the accommodation, care, services, programs and goods provided...to the residents of the home."

These requirements would be difficult to meet given that the bill provides no assurance that the needs of new residents can be met by the home to which the applicant has been directed by the placement coordinators.

We offer three possible scenarios:

- (1) The homes could develop plans to meet all possible needs, thereby diluting the quality of all programs;
- (2) Homes could continue with their current programs in order to ensure their quality is high and choose not to make available any other programs, thereby refusing to meet the needs of some residents; or
- (3) A home could cut or discontinue discretionary programs in order to make room and/or time for other programs.

We see a solution for this and would like to offer that the homes should have the legislated right to appeal or stop actions which are deemed to place the homes' safe and competent care in jeopardy. Otherwise, what rights do the homes have? The next sector would be medical director involvement. Under the current act, the current regulations involve the physician of the home in the assessment of an applicant. It states: "Where, in the opinion of the physician of a home and the administrator, the mental and physical condition of an applicant is such that the applicant cannot be properly cared for in the home the applicant shall not be admitted to the home."

Under Bill 101, the medical director's involvement in the admission process appears to have been eliminated, as there is not explicit identification of any involvement that the medical director may have in the admission of a senior to a home.

Bill 101 states: "A person may be admitted...only if...a placement coordinator has determined that the person is eligible for admission...and the placement coordinator designated for the approved charitable home...has authorized the admission of the person to the home."

It further states: "A placement coordinator to whom application has been made...shall determine in accordance with the regulations whether the person is eligible for admission."

The bill explicitly states that two levels of placement coordinators will be in place. The first level of placement coordinators serves to determine whether or not an applicant is eligible for admission to a home, and the second level of placement coordinators who are placed at the individual homes determines if an applicant is eligible to enter that home. There is no mention of a medical director at any time.

Furthermore, the current pre-admission assessment serves as an opportunity for bonding between the client and the physician.

The next sector is immunity. The bill explicitly states that the placement coordinators are immune from liability for any and all mistakes they may make. It states: "No proceeding for damages shall be commenced against a placement coordinator or a member, employee or agent of a placement coordinator for any act done in good faith...or for any alleged neglect or default in the performance...of the person's duty."

We ask: What are the implications of this power?

Obviously, this section of the bill leaves the home liable for the actions of placement coordinators. The options are either that the homes also be immune from liability or that everybody be responsible and accountable for their actions and therefore this section should be removed from the bill.

Under monetary issues: Long-term care facilities are different from residential facilities. Pioneer Manor is a home for the aged run by the regional municipality of Sudbury. If it's to become a long-term care facility, there are certain items that will have to be installed, such as a call bell system, a bedpan flusher room, a nursing station and lifting equipment.

Under the current act there is provision for subsidy for up to 50% of capital expenditures. The act states: "When the site and plans of a building to be acquired, erected or altered for use as a home...the minister may direct payment...of an amount...not exceeding 50% of the cost."

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Bill 101 does state that additional grants may be given to the home as a result of an extraordinary event. The bill states: "The minister may, out of money appropriated by the Legislature, make a grant...to assist in defraying the costs incurred or to be incurred ...as a result of the occurrence of an extraordinary event." What does "extraordinary event" mean, and what are your criteria for this?

So unless upgrading a residential facility to a long-term care facility is considered an extraordinary occurrence, it is likely that no grants will be issued to Pioneer Manor to assist the home with the four items that we would be needing: a call bell system, a bedpan flusher room, a nursing station, and lifting equipment.

Staffing requirements are another concern. The standards are different for long-term care and residential care facilities. Currently, Pioneer Manor staffing just passes the minimum staffing level for extended care. Should Pioneer Manor be required by the placement coordinators to accept some long-term care residents, they will have to increase the staffing complement in order to meet the minimum staffing level required. It is not clear whether the province will be able to pay for this increase.

Another sector is the operation of residential services. Section 9.5 of the bill gives a great deal of power to the placement coordinators. Nowhere in the section does it provide power to the home to admit residents.

Pioneer Manor is operated, as I said, by the regional municipality of Sudbury. It has 176 residential beds out of a total of 349 in this facility. Pioneer Manor is rather unique because its residential per diem costs are \$46, and given the \$38 copayment mentioned by the Ministry of Health last December, plus the supplementary fee for preferred accommodation of \$10, we will have \$48, which provides a \$2 margin. So it is viable; Pioneer Manor can continue to afford to provide residential services. I think our biggest threat is that the home will have no more powers to admit residents.

We have some questions. Will homes for the aged be given the right to admit our residential clients? If not, who will advise the 80 families in Sudbury already on the waiting list for residential care? Have they been advised of the proposed changes to the Homes for the Aged and Rest Homes Act?

To conclude, I am certain you will be hearing from many concerned organizations regarding the proposed Bill 101. We believe it has been drafted too hastily and has not been thoroughly thought through. Secondly, we are certain that many of the persons and families to be affected by Bill 101 are not aware of its contents, and every effort should be made to ensure that this very important legislation is thoroughly discussed with the stakeholders.

Thank you for the opportunity to present our concerns to the standing committee on social development. We are certain that after you have prepared your summary, the government will give it the time it deserves to address the specific concerns.

The Chair: Thank you very much. We're pleased to have the views of the regional municipality, because obviously this bill has an impact on your programs.

I'm going to begin just with the parliamentary assistant. He wanted to make a few clarifications. After that, we'll move to questions. Mr Wessenger.

Mr Paul Wessenger (Simcoe Centre): Thank you for your presentation. What I thought is that we'd have some clarification with respect to the admission procedures and with respect to the long-term care facilities, which I think might help clarify some of your questions.

One thing I might add with respect to the question of refusing clients admission: There would be grounds provided under the regulations, and the basic premise on which those regulations will be based is that the facility would not be in a position to service the client, whether that would be for physical care needs or for perhaps particular social aspects as well.

With that, I'll ask our staff to indicate the procedure with respect to the admissions.

Ms Gail Czukar: I'm Gail Czukar, counsel with the Ministry of Health, and I thought I would just clarify the admission procedure.

You're right that there are two roles that the placement coordination services play. One is to assess the eligibility of the applicant for facility services, and that can be done anywhere in the province by any placement coordination service, a basic determination of eligibility for our facilities. Then the placement coordination service that relates to the particular home determines the admission to that home.

The first level of determination is appealable—that is, the basic eligibility for service—which is based on an assessment of the person's needs and so on. The second one, regarding admission to the home, is not appealable under the bill because it's basically a priority-setting exercise among all of the people waiting for placement in facilities in that region. It's done on the basis of highest need, so that people with the greatest need get the beds first.

The placement coordination service, in determining whether to authorize admission to a particular home, obviously will take into account, first and foremost, the preference of the client. There will be different waiting lists maintained for different homes, so that no one can be required to go to a home that he doesn't choose. That would be the first criterion once they are able for placement, that they would choose which home to be placed in.

The home, likewise, can refuse admission to an applicant whom they feel they're not equipped to serve in the way that Mr Wessenger mentioned: that they don't have the physical facilities that are appropriate for the person or they don't have staff who are adequately trained to take care of the person. That would be taken care of in the normal negotiations between the placement coordinator and the home before the person's admission is authorized.

So the placement coordinator can't authorize admission to a home for someone who doesn't choose to go there.

Ms Wong: Where in the legislation is that addressed? Where is the wording in the legislation that will tell me that it's there? It's not specified.

Ms Czukar: The criteria for eligibility. As it says, the placement coordinator is to determine eligibility "in accordance with the regulations." So the criteria for eligibility

will be spelled out in regulations, and likewise, the criteria for authorization of admission will be in the regulations. Legally, it wouldn't really be possible to admit someone to a home or to force them to go to a home, because there's no authority to do that. You'd need legal authority to admit someone involuntarily, but you can't really force someone to go somewhere without his consent.

Ms Wong: I will take your word then that this will be addressed in the new legislation, that clients have the right to choose

Ms Czukar: In the regulations. The parliamentary assistant may wish to say more about that.

Mr Wessenger: Yes. I'd just like to indicate that we are looking at the situation of whether we can give some more assurance of the aspect of consumer choice in the statute itself, as distinct from the regulations. We are looking at that to see if there can be some way of giving some more assurance in that area. But I can assure you that consumer choice is a very essential part.

Of course, the person who makes those choices probably would go to the placement coordinator and say, "My first choice is going to institution A, and second is B," and when an opening occurs at the place of first choice, that person would then have the opportunity to go there.

The Chair: Mrs O'Neill.

Mrs Yvonne O'Neill (Ottawa-Rideau): I want to thank you. I didn't think I'd see you quite so soon again, but here I am.

I'm very pleased that you brought forward the concerns you did. We certainly heard them from several others. But you were specific about the appeals being time-limited to 30 days; I think that's a very important intervention. The role of the medical director being highlighted is also helpful. And I'm very pleased you were as specific as you were about the capital expenditures that will be necessary in facilities that you are responsible for.

Municipalities have been coming forward. I think I'd like to see them come forward in larger numbers, because there's certainly a very important partnership that has been always in existence here.

Your last page is where I want to ask the questions, because I feel, in certain communities more than in others, that you're right, that people aren't aware of the contents of Bill 101. It's not an easy bill, for one thing, and, in amending six or seven other bills, it is never an easy piece of legislation to get hold of. Could you give us some suggestions on how we could be sure that it is being more accessible to the public? You were suggesting further discussions with the public; you hope there won't be any unnecessary haste here. Could you give us some suggestions about how, beyond these hearings, we as legislators could help this happen?

Ms Wong: I realize that there is an earmarked time to pass this legislation, and I wonder if you still have time to have a public forum. Like, how many people are in there who are not service providers, and how many people actually have clients or families involved using the service? That's the group that should also be reached. I think we service providers always seem to know what's happening,

but I think people who actually use the service should have this kind of process so that they can express their fears and their concerns

0930

Mrs O'Neill: Have you noticed the role, or let's say non-role, of residents' councils in this particular bill, that there is not a real thrust towards residents' councils?

Mr Cameron Jackson (Burlington South): They're not mentioned at all.

Ms Wong: But on the timing, it's too fast. Everything hasn't been thought through thoroughly.

Mrs O'Neill: Well, if you can think of ways in which we can communicate better with the people in the communities, I would like you to forward them to Mr Beer, our Chair, and I'm sure that with this challenge you will respond, because you're a pretty active thinker, Mila. Thanks.

Mrs Margaret Marland (Mississauga South): It's interesting that Ms O'Neill raises the non-reference to residents' councils, because one of the most detailed, most professional and also most poignant briefs that I have seen was written and presented to the minister by the residents' council of the Mississauga Hospital, which happens to be chaired by a woman who is a registered nurse who is a quadriplegic through—goodness, I should remember—but she's been living in the hospital, by necessity, since she was 34, and I think she's about 47 now.

It's a very different perspective that the residents' councils bring to this bill, but I think, like everything else, that brief was received by the minister and totally ignored by the minister and her staff, unfortunately, because it was received before the bill was drafted. It was during the public hearing process.

I just wanted to congratulate you on your presentation this morning. You have really touched some very important areas, and I think when you talk about the criteria for eligibility, it's a tremendous frustration for those of us, especially in opposition, when we deal with any legislation for which we cannot see the regulations. The problem is that all legislation has regulations, but in this case the regulations are terribly important. Not only do we not see them, we never have a chance to debate them on the floor of the House. We're really strangled by that fact, and very terribly limited. We can't bring that back in the House except as a reference during a debate, but we're never in the position to say, "Look, this regulation is totally unjust," or "This one won't work."

So we are very frustrated, and agree with a lot of what you've said this morning. We really appreciate your being here.

Mr Drummond White (Durham Centre): I was very interested in your lumping together the appeal issue and consumers' choice at the beginning of your presentation. Frankly, I'm not sure I quite agree with Ms Czukar. I think that people should have the right to appeal a decision; not the issue of whether or not they are placed or not placed, but where they're placed, how they're dealt with, what level of service they're given. It only makes sense to me that while no one is going to be forced to go into a home that they don't want to go into, in many situations

people will go into an inappropriate home simply because there's a space there. I think that in the meantime, that individual should have the capacity to appeal.

Ms Wong: Right.

Mr White: I'm wondering, do you think that should go to every decision made by a placement coordinator?

Ms Wong: I think that should only go to that point if the client, or the resident, the potential resident, doesn't want to go to that home. I think the biggest thing here is that that person must have the choice. And if the decision of the placement coordinator is different from the choice of the client, the appeal process should not be after the fact.

Also, the criteria where you can make the appeal are very specific, only upon the rejection of the coordinator, and that doesn't give a lot of leeway for the clients. You know, when you're dealing with people this age, that's an awful lot of stress. That's an awful lot of stress with people who are not too well and kind of frail. You subject them to that.

Mr White: Conversely, for those people in their midlife who are dealing with those folks, who may urge them into whatever decision the placement coordinator might offer simply because it relieves that relatively young family of an extra burden.

Ms Wong: Right.

The Chair: In Thunder Bay and in London we heard about the placement coordination services that exist right now and it's one of the questions we've wondered about. How do you handle that right now in the region? Do you have a group of the different agencies and so on that come together, or how is that function carried out at the present time?

Mr Mieto: Perhaps I can answer that. We have a placement coordination agency in this community administered by the VON. We and the home for the aged from the region are also participants on that, on an advisory committee, and it's working very well in terms of the services and opportunities and information it provides to the consumers and their families. They have an excellent staff. We work very closely with that organization in its present mode and format and see no problems with it in its current structure.

The Chair: Is that region-wide?

Mr Mieto: I believe it covers two districts, the districts of Sudbury and Manitoulin, which are much greater than the regional municipality of Sudbury.

The Chair: Thank you very much for coming before the committee today with your specific suggestions. I can certainly assure you that the committee will take those under advisement as we go about our deliberations.

Ms Wong: Thank you.

PERSONS UNITED FOR SELF-HELP (NORTHEASTERN ONTARIO REGION)

The Chair: I now call the next representation. I believe on our schedule it says the Ontario Advisory Council on Disability Issues but the representation is really being made on behalf of Persons United for Self-Help, northeastern

Ontario region. Is that essentially correct? I want to thank you for coming before the committee. I think we had some of your colleagues in the Middlesex area before us last Thursday from PUSH. If you'd be good enough just to identify yourself for the committee and for Hansard.

Ms Joanne Nother: Good morning. My name is Joanne Nother. I am a member of the Ontario Advisory Council on Disability Issues and I represent northeastern Ontario. I also am the chairperson of Persons United for Self-Help here in northeastern Ontario.

The Chair: So it's a multifaceted presentation.

Ms Nother: Exactly. The views I will state this morning are the views that are reiterated by my fellow colleagues on the advisory council and have been stated by Shirley Van Hoof, the chair, who you may have heard in London.

So good morning, everyone. I thank you for the opportunity to speak to you this morning. What I'd like to do is, I'm here to tell you that generally we support Bill 101, the redirection of long-term care, and welcome the shift in focus from the institutionalization of the elderly and persons with disabilities to supporting people in their own homes.

Direct funding to enable physically disabled adults to self-manage service empowers people with disabilities to make the choice to remain in their own homes. Direct individualized funding will allow me to choose the following: who assists me when I need and want assistance; where I will get assistance, ie home, work, travel, should I choose to stay at home; and with what I need assistance. I would be able to hire, train and manage my own worker. I could then schedule and pay them accordingly. I could choose to do all of this for myself, but for those who cannot or choose not to, an advocate can be appointed.

0940

There are many people, both physically disabled and elderly, in chronic care wards, extended care facilities and nursing homes who may not need to be there. Given the proper supports in the community, they could be living at home. If they are given the choice, some will choose not to leave the facility, but some will. The important factor here is that people be given the choice.

Having the choice will give me and others like me the chance to live a more normalized lifestyle. It will definitely give me and others like me more control over the day-to-day routine of our lives. Family relationships, which often are ignored or exaggerated by the sole care giver's role because of the dependency, may now have a chance to approximate normalcy. Having more choices definitely means that the disabled will not be tied to their homes but will have more mobility, provided, again, that transportation is not a factor.

We applauded the Minister of Health when she announced on December 2, 1993, the expansion of the integrated homemaker services program into Sudbury. This will make home care services available to consumers regardless of whether or not they need professional health care services. This part of the redirection strategy begins to

address the issue of available community supports. It is very important these supports be in place prior to any deinstitutionalization. If not, the long-term care redirection will not succeed

As I stated earlier, PUSH northeast and the Ontario advisory council support long-term care redirection as embodied in Bill 101. However, we do so with the following caveats: that the community support services must be strengthened and funding increased dramatically; that institutionalization of the elderly and persons with disabilities be an option accessed at their discretion when necessary for their continued care and at the level needed to maintain that care; and that amendments to current legislation proceed quickly to allow universal availability of the direct funding option for attendant services.

Further to this, we would like to see any pilot projects considered to test the option of direct funding abandoned. We see no need to continue to test a system that has been in place and working for years. By this I mean that orders in council to allow direct funding have been used by individuals with disabilities for at least 15 years that we're aware of and we feel that they have been sufficient tests of the process. We see no further need to spend government time and money on piloting an idea whose time has certainly come, and by that I mean the direct individualized funding.

We have lived through two governments proposing this long-term care redirection and we definitely think it's time for its fruition. I trust you will consider the concerns I've addressed with all due consideration. If you have any questions regarding any of the issues I've raised, I'll be more than willing to answer them. I thank you again for allowing me to speak to you today.

The Chair: Thank you very much for coming before the committee and for speaking in particular to that issue that is in the bill. We'll begin our questions with Ms Marland.

Mrs Marland: Thank you, Joanne, and congratulations for the fact that you are sitting on the advisory council. That's a very important organization—body, I should say—in the province. I am very familiar with PUSH because I am the spokesperson for our PC caucus in Ontario for people with disabilities.

I too support the direct individualized funding. My concern is that, while that is one of the aspects of this bill and one of the present promises of this government, this same government is currently ignoring a section of our disabled community very badly, so of course I perhaps don't have quite the faith and confidence in the government that I might otherwise. This current Bob Rae socialist government has cancelled the funding for sheltered workshops, so our developmentally disabled people in this province had to rally to the front lawns of Queen's Park in November; 4,000-plus people had to come to try to tell this government that couldn't understand what any cuts to any section of our community with disabilities mean. So I'm trying to be optimistic about the individualized funding because I think it's just purely common sense. You did refer to the fact that funding would have to increase substantially for this to be achieved.

I want to mention also that another member of your advisory council on disability issues, Mr Van Hoof, spoke I think in London and he talked there about the concern of repeating the mistakes that were made in the early 1960s and 1970s when our government decided to remove people from another form of health care, namely, psychiatric hospitals, without having community-based services. My concern about this legislation is that it's very dependent on the community-based services being in place and I would like to ask you if you share that concern, particularly in the north, because I have heard that the access to these community-based services have to be such an integral part of giving people the choice and being able to manage at home rather than being in a chronic care facility. Do you share that concern?

Ms Nother: Yes, I do. We do have grave concerns with regard to the disparity we suffer in the north. We have fewer health care professionals so we have less services when it comes to physiotherapy, occupational therapy. I guess it makes it more contingent upon having a community-based service everyone can access.

We suffer too and I'm concerned with regard to government cutbacks in the home care hours, in that whole arena, because if we don't have that community support, then it will be very difficult to maintain a residence in the home and to be able to stay in the home. I'm also concerned with funding for transportation for the disabled. It all ties in. We're not just talking about money to be able to pay an attendant to work with me; we're talking about all the rest of the community supports, and my fear is that we rush headlong into direct funding. I think direct funding is necessary. I know myself, from a personal viewpoint, I could begin direct funding tomorrow. But for all the others who need a greater amount of community support, I worry for those, because in this community and in many communities in the north, the systems are not yet in place, and I don't know when they will be, to begin this kind of direct

Mrs Marland: Mr Chairman, I'd like to correct my own record. I did not hear Dr Van Hoof in London, I had received a brief, and I've just been advised that it's Dr Shirley Van Hoof, so I would like the Hansard to refer to her in that correct gender. Thank you.

I just want to say finally, Joanne, when you're talking about the cuts in funding, the respite for the care givers, where there is not an independence of the person who has those special needs, is a major area of concern and it's the respite program that has also been cut for the developmentally disabled by this government currently.

0950

Mr Randy R. Hope (Chatham-Kent): Good morning, and thank you for the presentation. I'll speak a little bit differently than what Margaret had. I'd put a little bit more positive attitude towards this legislation. I know that the organization, through PUSH, played an active role for a number of years, because in the presentation given to us in London, they went through a number of reports that were put forward to other governments that never acted on those. So I think this is one positive step.

There are two areas where I'd like to touch base with you. The first one is about pilot projects. I know in Thunder Bay they were lobbying, saying, "We'll be the pilot project." In Windsor, I believe, they'd just started up and they weren't sure about the pilot. In London they were talking about the pilot project. Today, your comments say: "No pilot project. Let's begin. We've done enough studies. We have the example." I just wonder if you could elaborate a little bit more about why you feel, other than that it's been going on for years—but I just wonder if you could elaborate just a little bit more on accountability and other aspects.

Ms Nother: I guess to some extent the feeling is that we've done orders in council for many years which have covered the issue of direct funding for individuals to be able to pay for attendant care and whatever services they required through funding given to them through this order in council. It's our feeling that these have been a sufficient sense of how the process will work. To our understanding and for the people whom I know who have been involved in such a process, they have worked.

We still, to whatever extent, do not, again, have any regulations on how direct funding will be proposed. We don't know about accountability. We don't know who will cover Workers' Compensation. We don't know whatever. We'd like to see more, for sure, but we would also like to begin the process right away. We really think enough has been said with pilot projects and we'd like to start right away.

Mr Hope: There is one other area. As we listen to this public hearing process, we hear different viewpoints on different things. One of the areas which you were talking about was a minimum standard that had to be met for individuals that you wish to hire. I wonder if you would comment on that for us please.

Ms Nother: Sure, I can comment. PUSH Northeast right now is in the throes of working with Cambrian College and various other agencies and organizations in Sudbury looking at preparing an attendant care training program which we will use through the colleges. We've been in contact. We've just begun contact with a policy adviser with the long-term care division. We would like to work through MCU or now the superministry with regard to creating a standard and a training program for attendant care.

Mr Hope: But one of the concerns that was brought up to us during the presentations was, if we teach them in the academic field or in the college, then they're going to come in and tell me how they should bathe me, how they should lift me. That was one of the concerns that was brought up. If you have too much of a model for attendant care, then they take that model that they were educated on and bring it to your home, tell you how to bathe, not listening to you orders. I'm just wondering, do you see that possibility of a fear?

Ms Nother: We're proposing a program whereby attendants and persons with disabilities could be trained at the same time. What we're looking at is, say, a 16-week program to train individuals as independent living assistants or whatever and a 16-week self-advocacy training program for people with disabilities whereby we can teach

them how to train, how to interview, how to work with an assistant and an attendant.

For the most part, many individuals have not been involved in the process of hiring or interviewing attendants; they've been sent an attendant from an agency and that agency decided what person would work or not. You never had a chance to really work on a fit. Working with an attendant is such a personal relationship. It's more than slotting somebody into your house to wash your face or change your clothes and that type of thing, so there has to be some sort of fit.

What we'd like to do is develop a program whereby we could work one with the other so the attendants would be able to work with the actual individual needing the service, plus we'd be able to build in from experience and from people like myself—and the programs would be consumer-driven—as to where the problem areas would be with the attendants.

Communication's a big factor. How do we train independent living assistants to work with people with disabilities? Let's get away from the medical model and turn it more towards a personal care model so that someone who works with me isn't standing over me with a white coat telling me I should do things in five minutes, tapping their feet, grabbing my cereal bowl and that type of thing when they think I should be finished. We want to work it out so it's a little bit of a better fit for us as individuals.

Mrs Elinor Caplan (Oriole): I was in London and I heard the very excellent presentation that you referred to and I'm aware of the frustration that many people have about how unbalanced this legislation is. After two and a half years, we still don't have a long-term care policy framework. After two and a half years, the chronic care hospital review is not complete, and this legislation, with the exception of the opportunity for individual funding, really is institutional legislation.

We have seen, in my view, over the past two and a half years a remedicalization not only of the delivery of health services but also of long-term care policy because of the development of this legislation in the absence of the overall policy framework. So I understand your concerns. I know that as I've been making my points, Hansard cannot record the fact that your head has been nodding in agreement, so if you'd like to make any comment on that before I continue, I'll give you the chance to do so. Is that a correct assessment, in your view?

Ms Nother: Yes, I agree with what you stated.

The Chair: That is the sound of nodding heads.

Mrs Caplan: It is important. It's been three years since Mr Beer announced the initial funding for 500 directly funded—at that point I think it was announced as a pilot, but in fact the numbers were there and the dollars were committed, and we have yet to hear what is actually going to be committed under this policy by this new government. I know that there are many concerns, not only from PUSH but others in the long-term care field.

I don't have a lot of questions for you, but there is one point I would like to make to Mr White, who's looking quite uncomfortable sitting in his seat at this moment, and I think he should. The point that I want to make is, as a member of the advisory committee, you would know that staff of the ministry and advisory committees and so forth advised the government, is that correct?

Ms Nother: Yes, to some extent.

Mrs Caplan: But that it is the government, the ministers in particular, who make the decisions?

Ms Nother: Exactly.

Mrs Caplan: So that when Mr White says he doesn't agree with Ms Czukar, what he really is saying is he doesn't agree with the policy decision made by his government, because they would have been the ones who decided on what rights of appeal, what the framework of the legislation looks like. Is that fair?

Ms Nother: Yes.

Mrs Caplan: And it's not just not a good idea, but I think it's very unfair to blame the bureaucrats or to blame an advisory committee if your minister and your government have made a wrong policy decision. I would point out that this is the opportunity for this committee to correct some of those policy decisions that have been perhaps misguided. Some of the things that we're proposing at this committee and will be proposing will be some amendments to perhaps, if possible, convince the government that this legislation could be significantly improved.

But my own feeling—this is the one question I have for you—is that we have had an undertaking from the parliamentary assistant that the long-term care policy framework should be out in March; that the chronic care role study should be completed and ready for public discussion in March. In light of all of that, is it your view that this legislation, hopefully with some positive amendments that will ensure residents' councils and reinstate the rights of appeal not only for consumers, but I believe institutions should also have the right to refuse if the placement coordinator's decision is going to result in inappropriate care—I believe as well that that should also be subject to appeal. If we can fix this, is it your view that this legislation should go forward because the disabled community has been waiting for so long? Or should this, in your view, wait?

Ms Nother: No, I agree. With the amendments as indicated and from, I'm sure, all the presentations that you've heard to date, with those amendments taken into consideration, I think the long-term care redirection should go ahead as proposed.

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Mrs Caplan: I know many people share my disappointment that this legislation is really incomplete. It's been advertised as long-term care legislation, but really it only relates specifically to a very small component of overall long-term care reform. Did you want to comment on that?

Ms Nother: No. With regard to what you're saying, I agree, and I think long-term care reform is more than just some of the amendments as we've stated with regard to institutions.

With regard to the direct funding, there are many other concerns and recommendations that we've seen through committees and consultations we've held at community and municipal levels, so I really think, with proposed amendments, we may have a framework with which we can then work.

The Chair: Final question, Mr Bisson?

Mr White: After Mr Bisson, Mr Chair.

Mr Gilles Bisson (Cochrane South): Just very quickly, one of the things that you touched on is the whole question of the depopulation of our institutions that we have across the province, something that started quite a few years ago, and as a premise, I just want to say that initially I was very much opposed to that move because of what it meant in regard to the institutions.

But through personal experience—my sister's a schizophrenic and for the past four years or so has probably been served as well, or even better in some cases, outside of the institutions, within group homes etc, to get the kind of service, quite frankly, that she couldn't get in an institution-type environment. So I'm a latecomer to support.

I too fear some of the difficulties around the whole question of funding about how, if we're going to get people out of the institutions over a long term, we provide for the proper services within the community. I know that your group and others have been dealing with that question for a long time, and the question I have for you is, what kind of advice can you give in regard to—there's no magical solution. I don't care who the government was, today, dealing with this issue, we'd all be grasping with trying to do that in as user-friendly type of way as possible, and I'm just looking for a bit of advice.

Ms Nother: Yes. With regard to the bit of advice, we definitely do need to have all the consumer-based services in order for us to make a go of living at home, and I really think that it's only fair to expect and hope that they will be in place before I make the decision.

With regard to any further advice, I'd like to say that consumer involvement is extremely important in being able to say what should be accessed and how it should be accessed, because there is nothing more frustrating to me as a consumer than having a group of service providers and administrators determine what I need and how I need it and how I should access it.

The Chair: I want to thank you for coming before the committee and making your presentation. We appreciate it.

I'm going to call the next witness and then recognize Mr White. If the representatives of the Seniors of Espanola Nursing Home would come forward, and as they are coming forward, Mr White?

Mr White: Thank you, Mr Chair. I just wanted to clarify the record in regard to some comments that Ms Caplan made.

Mrs Caplan: No. You clarify the record according to what you made. Start by an apology to Ms Czukar.

The Chair: Order, please.

Mr White: I would like to simply clarify that while Ms Czukar is absolutely correct that no one can be forced to go into a nursing home beyond their wishes, the issues within a social milieu, within a placement milieu, I think go far beyond that, and that's the point I was trying to make, that the bill should be sensitive to those issues. I'm not at all in disagreement with Ms Czukar's interpretation of the law nor our government's policies.

SENIORS OF ESPANOLA NURSING HOME

The Chair: I want to welcome the representatives from the Seniors of Espanola Nursing Home. Thank you for coming to the committee this morning. If you'd be good enough just to introduce yourselves for the committee members and for Hansard, and then please go ahead with your presentation.

Mrs Stella Rooney: My name is Stella Rooney.

Mrs Lynda Carey: I'm Lynda Carey.

The Chair: Welcome.

Mrs Rooney: We are here today to represent the residents of the Espanola Nursing Home. There are 30 residents in the home. We have come with the full support of the residents and their families as well as the full support of the municipal council.

They feel that the pending increases are totally unacceptable. We are here today to present their objections and concerns regarding the amendments to Bill 101. We feel that the amendments are aimed at a vulnerable group. Many of the seniors are unable to speak for themselves and their families are at a loss as to how to deal with this situation.

What the Rae government is about to do to the seniors is unconscientious. They have stated that, "Those we have targeted are able to afford it." The full increase is to be applied if a senior's annual income reaches \$10,680. The new rate is to be \$37.12 per day. That amounts to \$13,548 a year. That is a difference of \$2,868 a year or \$239 a month. Where is this difference going to come from? Some of the information that we have received indicated that residents who receive the Gains supplement to their pensions would be entitled to a rate reduction of half the increase, or \$5 per day. That is about \$150 per month. Where is this money going to come from? Even if the comfort allowance is used up by this increase, there is still a shortfall. Where is this going to come from?

There are many concerns about how the increases will be met. There is a struggle now for some families to meet the expenses because when their loved one was placed in the nursing home they were not able to get the accommodation of their choice. They were forced to accept semiprivate or private accommodations in order to have their family member placed in the home. In turn, this has put a financial burden on some residents and their families.

One major concern for some of our seniors is what happens when they can no longer afford the semiprivate or private room and there are no ward rooms available to accommodate them. Will they be forced to move out of the room? Will they be forced to move out of the nursing home? Will their families end up paying the difference? What happens if the family is unable to make up the difference? For many, their pensions do not cover the additional costs of a semiprivate or private room.

In a letter from Mr Rae to Algoma-Manitoulin MPP Mike Brown, he states that, "Accommodation costs will be based on an income test, that assets will not be considered in determining the fee that a resident will pay." Our residents are not convinced that their personal savings will not be considered on a means test.

The NDP government is making life very uncomfortable for a group of people who have done their part for society. They worked hard all their lives, paid taxes and supported government programs via those taxes, and now the government wants them to continue to pay at a time in their lives when they should be relieved of that kind of financial stress. The NDP will be taking away what little security some of these people have. The government is telling the seniors that they will have to take care of them if they cannot afford to meet the new copayments. Our seniors are not convinced, nor are the families who see to the interests of those who cannot speak out for themselves.

Lvnda will continue.

Mrs Carey: I spoke to a gentleman from the Royal Canadian Legion, and he reminded me of another section of our aging population that should be addressed. These people are the war veterans of this province. Many of these people reside in nursing homes. Some of them are there due to injuries suffered in the various wars that Canada took part in. These people risked their lives for this country, some of them are still suffering physically, and the country is now repaying them by making their lives more difficult to bear because of continuing high costs to stay in the only place left for them to stay. Any small increase they may get in pensions is quickly taken up by these high costs.

The Rae government indicated that it would be a Robin Hood for the least fortunate of this province, to have the more affluent section of the population pick up the tab, so to speak. This is not what is happening. Where is this government's social conscience?

1010

We also have some complaints as to the way these hearings have been set up. We feel that there have been attempts to discourage people from attending. First of all, the memorandum dated December 21, 1992, from the standing committee on social development in regard to these hearings was not received in our MPP's office until January 18. I have been made to understand that there were advertisements in the newspaper, but these were placed in the newspaper on January 1. I don't know whether that was the only time they were put in, but it seems like an awkward date. How many people really do pay attention to a paper on January 1?

The memorandum existed for almost a month before we were aware of it. We were informed by our MPP's office that we had until January 21 to decide if our committee wanted to be represented at these hearings. We had only two days to poll the seniors and their families and put together a committee to represent the residents of Espanola Nursing Home. There should have been more notice given.

To compound the problem, the dates of the hearings in Sudbury were changed and we had to rearrange our schedules in order to be here today. Other supporters had to cancel out. The memorandum gave no indication of where the hearings were being held. I had to call around in order to find out where they were being held and at what time. The agenda for the hearings today was sent out on Friday.

We feel that there has been a deliberate attempt to discourage people from attending these hearings. There has been very little in the news media about these increases. We feel the government has deliberately tried to push the bill through without properly consulting those affected. If there hadn't been such a protest, this may well have happened.

Another concern is this: Are we just getting lipservice from the NDP government? Are we just wasting our time, or is the government really going to listen to us and take our concerns into consideration?

What we are saying to the Rae government is that we don't trust it. When I first found out about these increases, I felt that Mr Rae was just shaking the tree to see what falls out. That's my own personal opinion. We feel that his government is out to relieve the seniors of their hard-earned savings, savings that give them some comfort at a time in their lives when finances should not be a major concern. Our seniors expect their savings to provide them with some comfort in their lives, comfort that comes from knowing they will not become a financial burden on their families. The Rae government has set out to relieve them of that comfort.

We hope the Rae government will pay attention to what we are saying. There is a tremendous need for this government to take the financial worry from this section of the population. I wish they could see the mental stress they are creating for some of these people. It would certainly make them think twice before proceeding with the amendments to Bill 101.

The Chair: First of all, as the Chair of the committee, I think it's important that I address your questions around the committee hearings. I really want to make clear that we have tried very hard to make sure as many groups could come before the committee as possible and in fact extended the deadline, and in terms of communicating with the groups that had been involved in the various consultation processes earlier, we were concerned that in some areas we weren't getting as much of a response.

The ad should have been in on January 8. That's when it was in all the other papers. There's always a problem with ads, in that, do people see them on the day they're there?

I certainly apologize if there wasn't sufficient time for you, but I can say that we as a committee, and I'm involved here with members from all parties, have tried very hard to contact as many groups, organizations and individuals who are interested as possible.

In terms of the earlier memorandum before Christmas, that was to tell people this was going to happen. At that point we didn't know where the hearings would be held in each of the different communities, but then once we had that information, again that went out to all the members as well.

My experience in the five or six years I've been a member—and I say this, and perhaps you don't know, but I'm the Chair of the committee but I'm not a member of the government party; I'm with another. I just want to make clear that—

Mr Stephen Owens (Scarborough Centre): You don't have to backwater that fast.

The Chair: No, but I think it's important in terms of there wasn't any attempt to dissuade people from coming before this committee. In point of fact, we all felt very strongly that—

Mr White: Wouldn't that happen if the Chair was a government member too?

The Chair: But I'm making the point in support of everyone on the committee that we really did try to get as many people to come forward as possible. It has been a continuing problem in my years in the Legislature that no matter how hard you try, somehow inevitably there always seems to be groups or a region where people have not heard about it. That's not acceptable, obviously, and, as the Chair of the committee, I am sorry you weren't aware earlier. But I do feel that, on behalf of all the members of the committee, I do want to say there certainly was no deliberate attempt to try not to reach people and we're very glad that you in fact have come, even though you didn't have as much time to prepare as you would have liked.

Mrs Carey: When was it decided to hold these hearings?

The Chair: At the end of the debate in the Legislature, this would have been—I forget the date in December.

Mrs Carey: That would have been around the 17th, 18th of December.

The Chair: It might have been a bit earlier. I forget when-

Mrs Marland: We rose on the 10th.

The Chair: The 10th? There's a decision made then that this bill would go to committee. Once that happens, then it comes to my attention as the Chair of this committee. I then had directed that a memorandum go out to as many groups as we could identify. We asked for input from all three parties. That memorandum went out. We then sent that as well to local members, and in particular, in early January, when we started to look at who had responded, I then sent a special note to all the members in the areas we were going to be coming, asking them if they would also check around and see if people had heard. The problem of Christmas and New Year's can often be a difficulty here as well in terms of reaching people.

I just wanted to put on the record that the purpose of these is to make sure that people do come forward, and when that doesn't happen, I think we have to continue to review our procedures and how we go forward, but I just wanted to make clear that if people didn't hear, it wasn't through any deliberateness on the part of the committee. We really wanted people to be here.

Mrs Carey: Is it procedure to arrange for the hearings after the debate and not prior to it?

The Chair: No, after, because one never knows whether in fact the bill is going to go to committee or not. This is a decision that is made in the Legislature. There are some times when that's known, but generally speaking that

is done at the completion of the debate, and that's why we got the memorandum out before Christmas, because we were just concerned that it go out.

Mrs Carey: We didn't see or hear of the memorandum until around January 17 or 18.

The Chair: I'm sorry about that. As I say, we wanted to reach more people more quickly. But we are glad that you have come today.

Mrs Caplan: Mr Chair, I'd like to just explain that I moved the microphone because of the static that was being caused and I hoped that it wouldn't interfere with your presentation.

Mrs Carey: That's fine. Okay.

The Chair: With that, and if I could just leave that with you, I just felt that I wanted to make it clear that if there had been some problems, they've been inadvertent and not through any plan. As I say, we're very glad that you did come today.

We'll move now to questions and we'll begin with Mr Wessenger.

Mr Wessenger: Thank you for your presentation. I'd just like to comment on some of your comments with respect to the legislation. I think, first of all, we should remember in this legislation that I don't think ever in the history of Ontario has there been such an extensive consultation with respect to any legislation.

Mrs Caplan: Wrong. We spent 10 years on the health professions review.

Mr Wessenger: Over 75,000 people were consulted with respect to the long-term care policy, so I think that was a very extensive consultation.

Mrs Caplan: It's a bunch of rhetoric.

Mr Wessenger: With respect to your comments on the payment aspect, what we're attempting to do is basically to provide a system of payment that is fair and equitable, based on ability to pay. As part of that, one of the aspects is that every resident will be left with at least \$112 per month as a comfort allowance, so that no one will have to go into their comfort allowance in order to pay their accommodation costs.

Mrs Carey: The numbers aren't adding up. People on Gains are allowed to apply for a reduced rate of \$5 a day. According to the information that I've been given, they are still going to have to come up with an additional \$5 a day.

Mr Wessenger: I'm told that that's not accurate, but I'll ask staff to explain that to you.

Mr Geoff Quirt: Geoff Quirt. I'm the acting executive director of the long-term care division.

The new resident payment system would work as follows: The rate of \$38 and some odd cents will be set in direct relation to the level of income that someone would have to have to be no longer eligible for the guaranteed income supplement. So residents would be asked the question, are you in receipt of the guaranteed income supplement? If they said no, they were not, then we would know that their income from other sources would be sufficient

for them to be able to pay the \$38 and still have \$112 a month left over.

If anyone said that yes, they did receive a portion of the guaranteed income supplement from the federal government, then they would be entitled to a rate reduction. Their rate reduction would ensure that they paid a rate that would still allow them to have \$112 a month left over.

Anybody who received any portion of what you referred to as Gains, which is the supplementary cheque from the Ministry of Revenue in Ontario for very low income seniors, would still pay the basic copayment as you know it now, the \$26.26, so that even he would have \$112 a month left over for his comforts.

Mrs Carey: Now, I referred to assets. As you mentioned before, Bill 101 is a cumbersome document, and I was unable to find anything in there that would indicate that their assets would not be considered.

Mr Quirt: There's nothing in the bill that speaks to it. I think the bill simply says that the copayment resident payment system would be defined in regulation.

But the Minister of Health has been very forthcoming in saying that the new system would not take into account people's assets. In other words, as is the case now for residential care residents in municipal and charitable homes for the aged who are asked to pay the full cost, not only their accommodation but their nursing services and their other programs, their assets are taken into account to the extent that residents with limited income but who have assets, like a farm or a house, have run a big bill or run a tab, if you like, at the home for the aged, and that bill accumulates. When a resident passes away, a claim is made against the estate, against the value of the house or the value of the farm, by the municipality or by the charitable group, under the current system.

Under the current system, those residential care residents are asked to declare all their assets—for example, money in the bank or an insurance policy—and their entire worth is considered in determining whether they can pay the full cost of their care in residential care. Under the new system, only income, as declared to the federal government in their application for the guaranteed income supplement, would be considered in determining their resident payment.

Mrs O'Neill: I'm very pleased you came in and spoke so forthrightly. I want to say that I am supportive of what our Chair has stated.

I do feel, however, and I continue to remind people at Queen's Park, that there are communities in Ontario that do depend on weekly newspapers, and I know that's a very difficult bridge between the dailies and the weeklies. But in the north there are communities that are relatively isolated. I think the north has special needs, and I don't think we always are very sensitive to them in so far as communication is concerned. Communication was expressed by others in presentations already this morning.

I have difficulty with the present government's statements, from the minister on down, that there has never been so much consultation on a piece of legislation, because the consultation that is quoted as the 75,000 is what people hoped would be in the legislation. They were

discussion papers that were placed before communities. The discussion on the actual legislation has certainly not been any more outstanding than any other consultation that I'm aware of

I'd like you, if you could, to respond to a couple of my inquiries. The role of the residents' council seems somewhat neglected in Bill 101, to say the least. I'd like you to say a little bit about that, if you could. What is the percentage of residents that you feel in your facility would be affected by the changes regarding the copayment? Large number? Small number?

Also, again we're being asked to take a giant leap of faith regarding regulations, and I'm very pleased you've done as much homework as you have because I think you're trying to define exactly what effect Bill 101 will have on the financial flexibility of, in some cases, very vulnerable residents. So if you could tell us a little bit about how many will be affected and then the role that you see for residents' councils, I think that would be satisfactory for me this morning.

Mrs Rooney: I believe that there will be a large number at our nursing home affected.

Mrs O'Neill: Half?

Mrs Rooney: More than half. Mrs O'Neill: More than half?

Mrs Rooney: Yes. Much more than half. We have several people, my mother-in-law included, and I believe Lynda Carey's father-in-law, who were given a choice. You know, "You take this bed or you go somewhere else," like Thessalon or some far away place. Well, that's not a very nice thing to deal with. When you have that before you and you're sitting there with two members of the family to decide this with another person and you have your loved one, your mother-in-law, who has had a stroke and cannot speak for herself and you have to speak for her, you have to think quickly. We don't want her 150 or 300 miles away, we want her close to home. We want her at home if we can keep it there. The same thing for the men who are there and the other women.

There have been a few instances where this has come up, and so we have had to take the semiprivate room, whereas there are ward rooms. Ward rooms are identical. Elinor Caplan is very well aware. In fact, she and I toured the building together. These ward rooms and semiprivate rooms are identical, but the rates are different. My motherin-law, for one, is a widow receiving \$910.89 total. That's her senior citizen's pension, her supplement and a \$10 Canada Pension cheque. That's all she gets. But to stay there it costs \$1,104. I think that's very unfair. She has no assets like many of the others who are there. I'm speaking for many others, but I'm taking her as a very good example. They have no assets and they have no bank account and they are depending on their children, but their children are getting older. There's 10 years between my mother-inlaw and my husband. He's much older than I am. He will be a senior citizen next year. Maybe he'll end up in a senior citizen's home too. I guess he won't end up in Espanola if he has to go there.

It's the same thing with many others. There's a long waiting list. They're all worried about what's going to happen to them. They don't have the money. They don't have family that can give any more money. They don't have any assets that they can sell. So where is this money coming from? Where are we going to grab it from, if we can grab it? If the NDP government can grab millions of dollars somewhere—I won't mention the projects—and a few million dollars from somewhere else to do something else, why couldn't they have reached out somewhere in the air and gotten millions of dollars to keep our senior citizens happy, healthy and well taken care of?

Take their pensions, if that's what it has to be. But if they're going to raise this increase, where is it coming from? Where will they get it to stay in that home? They can't stay in the home, can they? Or will you allow them to stay there? Will the government allow them to stay there?

Mrs O'Neill: Well, we are sure hoping so.

Mrs Rooney: And you know yourself, as each year goes by, you get progressively worse. Is there anything else?

Mrs O'Neill: I guess our time is short. I did want a little comment on the residents' councils, if I could, and the role they play in your facility.

1030

Mrs Carey: The lady who was to represent residents' council was unable to come with us today.

Mrs O'Neill: Okay. Well, thank you so much for being as forthright as you've been in bringing very concrete examples of the concerns, because we know they're there.

The Chair: Mr Jackson.

Mr Jackson: This is a very strong brief you've presented. Words like Bob Rae being—

Mrs Carey: Unconscientious.

Mr Jackson: —unconscientious, thank you. "Where is this government's social conscience?" "We don't trust them." These are very strong words. Were you concerned that a year and a half ago, when this government got into difficulty—nursing homes were starting to close, banks were putting them into receivership—and all through that debate, not once did the Minister of Health mention, "I'm going to find this money on the backs of seniors"? She promised that she would increase the cash flow to nursing homes.

Did you ever anticipate that these socialists would bring in increased user fees, even when they campaigned so heavily in the last election? The Liberals and we, as Conservatives, took it in the ear, in the backside, everywhere from the socialists campaigning, who said we were the devils because we were going to talk about user fees. How do you feel now that this is one of the first major promises that were broken by this government affecting this issue of user fees?

Mrs Carey: I wish that some of the people who are involved in the amendments to this could see what kind of stress it's creating for some of the people. They're not in there on a one-on-one basis trying to calm their fears. There's one resident in particular whose big concern is, "Will I have to move out of my room?" She loves her roommate, she loves her room, she's very happy there, and

just the thought of moving even across the hall has got her in a tailspin.

Mr Jackson: The fact that this government has said, "Trust us, we're going to put it in regulations"—and the minister has consistently said that. Well, after this government—and I don't think they really, honestly lied to us two years ago at the polls; I think they believed that was the system they wanted. But as soon as they got in there, they realized that they're not going to ask unions to take a cut, they're not going to ask everybody to participate; it's the senior who have to take the hit, and they've protected themselves very cleverly by not allowing amendments. You said you're hoping for amendments. We can't amend this to include the structuring of the fees and the protection of the asset bases and so on and so forth.

Do you believe any more today the assurances of the parliamentary assistant over the previous assurances of the government that there wouldn't be user fees to assist those facilities that are nursing homes?

Mrs Rooney: Definitely not. Today I feel like "the Robin Hood of two years ago," because someone else said this before I did—"liars," is the word. Liars, liars, liars. Let's put it to rest.

Mr Jackson: They won't put it to rest.

Mrs Rooney: Straighten it out.

Mr Jackson: They want the flexibility—they call it flexibility, which is a buzzword for control. They want to ensure sensitivity. That means they want to be able to protect the rules of the game. Those are the buzzwords that governments use.

I wanted to commend you for raising the issue of our veterans, and we are going to hear from one of the legions this afternoon. I just wanted to share with you that my colleague, our Health critic Jim Wilson, has written to the Royal Canadian Legion assuring them that we were presenting an amendment to this legislation. It's one of the amendments that would be deemed acceptable by the Chair and legal counsel as fitting in the legislation, but it may not be supported by this government, which controls this committee in terms of numbers. But we are prepared to acknowledge in legislation the promise we made our returning veterans, that the cost of their sacrifice would not go unnoticed during their lifetime, and this would represent a watershed change in that understanding to veterans, all previous veterans of known record in this country's history. We in no way wish to disrupt that and we want to commend you for looking upon your residents with a keen eye to understanding the various mix and the various backgrounds of your residents and that there are a significant number of veterans in your care in the Espanola area. I wanted to thank you for mentioning that and I wanted to at least give you that assurance, that we would be presenting that amendment to ensure that on a need basis doesn't mean that a veteran with less acuity would be passed over and told, "I'm sorry, you don't fit the politically acceptable mix of residents in this home any longer." Those are words we should never have to say.

The Chair: Do you have any final comments you'd like to make?

Mrs Carev: No.

Mrs Rooney: I'll just get into trouble if I say any more.

The Chair: No, not at all. The purpose of public hearings is to set out what people honestly feel. This is the place to do it. We are here as legislators from the provincial assembly and that's why we're here. I want to thank you for coming. Again, I'm sorry that there were difficulties around coming, but we are glad that you came and we thank you very much.

Mr Bisson: Mr Chairman, could I just make a comment? I think it's important.

The Chair: Order, please. I'm just going to thank those who came. I'll call the next witness and you can make your comment. Thank you again and I call the Victorian Order of Nurses, Sudbury. Mr Bisson, with a short comment.

Mr Bisson: The comment was in regard to some of the facts that came before us in the last presentation I think were well-meaning but somewhat misinformed. What scares me about that is that if we're going back into our nursing homes in Ontario and talking about issues like this in the way they were here before seniors, I think it puts them into a state they don't need to be in. I go into my nursing homes on a very regular basis in my riding, as all of us do within our own ridings, because seniors are an important part of our community, and it's not to say there aren't problems, it's not to say that legislation can't be made right, but I think it's very important that we clarify some of the misconceptions around some of the points that were made in this last presentation, because I think if we went into nursing homes and talked to people the way some of this was, we could scare the bejesus out of them.

Mr Jackson: Truth has a funny way of doing that.

Mrs Caplan: They just don't trust you. They see you taking from the have-nots and giving to the haves. They just don't trust you Gilles, and with cause.

Mr Owens: That was so transparent.

Mr Jackson: Are you calling the previous deputants—

The Chair: Order, please. Mr Bisson, I think that is open to all members to do, but what we are doing with the committee is having members come forward.

VICTORIAN ORDER OF NURSES, NORTHERN BRANCHES

The Chair: I call the Victorian Order of Nurses, Sudbury, please, if you would be good enough to come forward. I want to thank you very much for coming before the committee, and if you would be good enough to introduce yourselves. Do you have a submission there? Do I see copies? Perhaps the clerk—oh, here we are. We'll get those and just circulate those. If you would be good enough just to introduce yourselves for the members of the committee and for Hansard, then please go ahead.

Ms Sharon Baiden: Good morning. On behalf of Victorian Order of Nurses, northern branches, Algoma, Kirkland Lake, North Bay, Porcupine and Sudbury, we are

pleased to come before the standing committee on social development. My name is Sharon Baiden, executive director of VON Sudbury branch, and with me this morning is Antoinette Blunt, executive director of the VON Algoma branch. Together we will be presenting a VON northern perspective on Bill 101 and the proposed amendments.

VON welcomes the opportunity to comment on the amended statutes of Bill 101 dealing with long-term care with respect to provincial subsidies for nursing homes, charitable homes for the aged and municipal homes, service agreements with operators and facilities, admissions by designated placement coordinators, plans for residents, quality assurance plans, inspections of facilities and grants to assist persons with a disability to obtain the required goods and services.

At the outset, we wish to express our respect and commendation to the standing committee. The result of the comprehensive review and concrete proposals for change will likely affect the nature and future of our health care system for decades to come. Bill 101 represents the initial reform of the long-term care system.

1040

Ms Antoinette Blunt: The Victorian Order of Nurses is a national charitable organization dedicated to providing health and related services to communities across Canada. As a major provider of nursing and other services in the home and community, VON believes that individuals have primary responsibility for their own health. The maintenance of health directly and positively affects the quality of their lives. The value and dignity of human life is respected. Individuals have the right to accept or refuse health care, to obtain information about their health and health care and to participate with professionals in making decisions about and plans for the provision of their care. Individuals and families are supported so as to enable them to live and to meet death in comfort and with dignity.

Access to comprehensive, compassionate, family and community-centred health care is the right of all individuals regardless of their ability to pay. Health care providers collaborate to develop, implement and evaluate services which respond to the expressed needs of individuals, families and communities in keeping with the principles of primary health care.

Volunteers make a valuable contribution by extending and complementing the services provided by health professionals. At the local, provincial and national levels, volunteers help to identify needs, formulate policy, plan, promote, support and provide community health services.

Community health services of assured quality are essential. VON has a responsibility to expand knowledge through ongoing research, program evaluation and education.

Ms Baiden: Since June 1990, VON has carefully considered the government's proposals for reform of the long-term care system. Through the change in government and the ongoing review of the long-term care system, VON has continued to be involved in ongoing discussion and response to the proposed changes.

VON branches across northern Ontario, covering Algoma, Kirkland Lake, North Bay, Porcupine and Sudbury,

have a cumulation of more than 400 years experience. Over the years, our branches have worked closely with the community in identifying needs for services and developing programs to meet these needs. Through the participation of VON staff, volunteers and board members, our local branches adhere to the VON Canada mission, goals and objectives, and ensure the maintenance of professional and administrative standards.

Governed by a voluntary board of directors, VON is represented by a cross-section of the community with a wide range of skills, expertise and commitment to directing the branch. The boards are fiscally responsible for branch activities and are responsible for overall directional planning.

Ms Blunt: VON employs a range of professional and support staff in the delivery of community-based services. VON is moving to an expanded role of registered nurses in primary and secondary care. Nurses have a key role in long-term care both in facilities and in the community. The unique role of the nurse focuses on individual and family response to illness and disability in long-term care and has a key role in health promotion and prevention. Nurses are equipped to respond to the diversified needs of the longterm care client. Registered nursing assistants are assuming an expanded role with less complex, stable cases still involving skilled nursing intervention, and home support workers are providing personal care under the supervision of a health professional. Thus, we have a multidisciplinary team working to assess needs and to develop care plans in partnership with clients.

As VON looks to the challenges of the future, we continue to examine a range of models for in-home service delivery in order to ensure the best services for the consumer. Consumers requiring long-term care services to promote their health and wellbeing should have a choice of needed services, delivered in their preferred location by their preferred provider within available resources.

In responding to the feedback received through consultation, we believe the government is committed to a continuum of services offered both in the community and in long-term care facilities. VON, too, fully supports a full range of services from which consumers may choose in order for individuals to be independent for as long as possible.

Our primary services have been in home visiting nursing with an ever-expanding role as needs of individuals have changed and the focus to community-based health care has increased. VON has noted a shift in nursing complexity to include high-level assessment and skill in areas such as palliative care, enterostomal therapy, diabetic education, advanced foot care, in-home intravenous therapy and pain pump management in both acute and long-term care conditions. Many of VON services are provided to the age group of 65 and older. Maintenance of health and restoration of health to optimal levels of functioning through teaching, wellness promotion and supportive care are the aims of VON programs.

Family involvement is critical to all aspects of service provision. Through teaching and support by nursing and other professionals, family are provided the skills to manage the elderly or chronically disabled. Trained volunteers are critical to supporting professional providers and family members in an environment where high-quality, cost-effective services are essential. Some branches in northern Ontario offer volunteer palliative care services as a means of providing ongoing support.

Ms Baiden: Programs presently offered by VON throughout northern Ontario include: in Algoma, visiting nursing, enterostomal therapy, shift nursing, palliative care speciality nursing, palliative care volunteer program, placement coordination service and foot care; in Kirkland Lake, visiting nursing; in North Bay, visiting nursing, early post-partum discharge, palliative care, shift nursing, Meals on Wheels and insurance company assessments; in Porcupine, visiting nursing, occupational health nursing and a seniors' safety program; and in Sudbury, visiting nursing, early post-partum discharge, palliative care, shift nursing, foot care services, adult day centre, placement coordination service, volunteer palliative care services, home support program, in-home respite services and insurance company assessments.

Our future directions include new and expanded community-based programs to meet the challenges of promoting a healthier and more independent senior population.

VON recognizes and supports the need for institutional care of the elderly as a necessary component in the continuum of long-term care services, and from this perspective we speak to the proposed amendments in Bill 101.

Ms Blunt: Bill 101 is an incremental improvement in empowering the consumer. In recognition of the consumer's right to self-determination, the consumer has the right to participate in decisions affecting him or her. VON believes that more emphasis should be placed on the right of the consumer to be a full partner in the planning for his care, including choosing the delivery model and the provider best suited to meet his needs. With this direction, we must also recognize the right of the client to accept reasonable risk in his or her preference of where services are delivered. VON recommends that consumers have the choice of location of services, in a facility or community setting within an envelope of available resources.

In order to ensure that the citizens of Ontario have reasonable access to services, it will be necessary to have core services in place in each community across Ontario. In many areas of northern Ontario where community and facility services are limited, VON questions the level of choice consumers will actually have. As such, we recommend that the government initiate core services, including both in-home and facility-based care, needed in each community in order to truly empower the consumer around choice.

Further, in considering the development of core services, VON suggests that the government evolve provincial standards to ensure the outcome and quality of service and programs delivered. Such standards would promote a high level of accountability. Development and implementation of standards should be encouraged in conjunction with consumers, government, professionals and agencies involved in the delivery of service.

The regulations to be developed to support Bill 101 are to establish guidelines which provide for facility rights regarding type of service delivery. We suggest caution be exercised such that regulations do not negate any possibility of consumer choice in northern Ontario, particularly for service delivery to multicultural groups and natives.

1050

Services to seniors and disabled adults have tended to be viewed from a one-way directional flow from home to nursing home or a chronic care facility as aging and disability progress. Provision of services in this matter lacks consideration of consumer need and choice. In providing a full continuum of long-term services, flexibility and multi-directional flow is necessary to meet clients' changing needs. Some individuals may require only short-term care in a nursing home or chronic care facility and with appropriate intervention may be able to return to home-based care with supportive services. Both consumers and service providers have the responsibility of ensuring appropriate planning is done to achieve smooth transition between and within the long-term care system.

Ms Baiden: The amendments start to standardize legislation for long-term care facilities but do not replace separate legislation. We note that the legislation does not address chronic care beds and are encouraged that the government will receive and review the report of the chronic care role study to address this role in long-term care.

The legislation allows for the government to designate the number of beds, to require certain types and capacity of beds for certain levels of care and service, but does not reference these requirements in terms of any planning process provincially, regionally or locally.

Planning responsibilities should be clearly defined. Decisions should be made at the level of service delivery so as to ensure all factors are considered, particularly multicultural and geographic diversity. We believe the decisionmaking authority should be close to the people. Planning provincially, regionally and locally, with clearly defined responsibilities, will improve efficiency. For example, provincial responsibilities could include the definition of core programs and the definition of a quality management framework, including standards, outcomes and reporting requirements. Regional responsibilities could include specialized service planning; for example, geriatric assessment and specialized rehabilitation resources. Local planning could include the continuum of care from health promotion, through rehabilitation to chronic-level care; inhome, community- and facility-based.

VON supports the lead role for local planning being expanded to the local district health council. In the past, planning has occurred at multiple levels with little coordination, which has caused fragmentation and duplication in some cases. District health councils are well-positioned to assume the role of leading comprehensive, coordinated planning for long-term care services.

While VON recognizes the complexity of the longterm care system, we believe that moving ahead with implementation of certain areas before the entire policy framework is debated may further fragment the system. We envision a fully integrated system of reform, with a strong emphasis on community-based services. For example, the proposed changes to residential care may lead to deinstitutionalization for some. In order to manage this group and those presently on waiting lists for residential care, we must stress the necessity for the implementation of community support services and health and personal support services.

In moving ahead with Bill 101, institutional care becomes the focus, rather than developing health promotion and community-based options. VON recommends that the implementation of the legislation be deferred until the policy framework is released and consultation has been heard.

Ms Blunt: Today in Ontario, the resources allocated to institutional care—for example, chronic beds, extended beds and residential beds—far exceed resources spent on community and in-home services.

We believe that the health care system as a whole is sufficiently funded. The rate of growth of health care expenditure must be contained if universal health services are to continue. A provincial plan is needed to define funding allocations based on strategic priorities and a system of accountability around cost-benefit and consumer satisfaction.

The legislation promotes fiscal accountability by a control on resource utilization, rather than on measures for resource outcome. For example, there will be controls on the number and types of beds, as well as associated costs, rather than evaluating the benefit of facility versus other types of care from a systemic and consumer perspective.

While a payment system has been identified based on consumer acuity, VON believes it is not an incentive for wellness, but rather an incentive for illness. Funding formulas are needed that will address the full range of consumer need and care provision, rather than acuity only. The funding formulas further lack incentives for discharge from institutional care back to community-based care and lack incentives for rehabilitation to other levels of care.

Cost-effective service provision is essential and VON recognizes the need for regionalizing specialty services in order to ensure a comprehensive package for all consumers. However, in northern Ontario, geographic dimensions must be considered when viewing services from a regional perspective compared to those offered in southern Ontario. Thus, we recommend that services be considered and planned for locally, as distance to regional centres could cause accessibility problems in northern rural areas. Innovative delivery methods, such as travelling consultants, could be considered appropriate.

Ms Baiden: VON fully endorses a total quality management approach to both care for in-home, community-based and facility-based services. The approach promotes consumer choice and empowerment through their involvement in the evaluative process of programs provided to them. The proposal promotes a control/regulatory model, rather than that of quality management. Control through inspection does not promote quality care nor achieve desired outcomes. Inspection has been shown to promote lack of trust in quality care from both the provider and the consumer perspective.

Empowering consumers in a total quality management approach strives to ensure the right services are offered at

the right time, in the right place, by the right provider. VON encourages the government to consider the concept of quality improvement to ensure high service standards and consumer satisfaction.

Ms Blunt: While there may be several agencies providing service to a client, the system must be structured in a way to ensure that the services are delivered to the client in a seamless model. The government should promote collaboration among existing community organizations to reduce fragmentation. In order to accomplish this, service providers need to look at creative ways in which they can work together towards the common goal of meeting client needs through a multiservice agency. In considering options for service delivery, it should be noted that VON is currently a multiservice provider of services and would be prepared to sponsor pilots. VON suggests that the long-term care management agency also provide community-wide information and referral services, as well as screening for eligibility of needed services.

The proposed legislation speaks only to facility-based services. As indicated earlier, VON views the reformed long-term care system as a fully integrated system of both community-based and institutional services. We wish to emphasize the need for collaboration and partnership between all groups involved in the delivery of long-term care services. Bill 101 does not speak to linkages or partnerships with community agencies. We believe this to be necessary so as to ensure smooth transition through services and to ensure a seamless provision of service to consumers. Flexibility and simplified access is critical to responding to consumer needs.

Prior to expanding facility services, other communitybased options should be explored. Additionally, utilization of community-based services in facilities, such as speciality consultation teams, should be considered in rationalizing resources and manpower.

Family care givers form an integral component in the continuum of service providers. Ninety per cent of the care and support received by people who live at home is given by family and friends. In order to optimize family involvement in the care of the long-term client, it is necessary to have available respite care services. Bill 101 includes short-stay accommodation availability in each facility. This is a respite option which is necessary in some case. VON further recommends that the government consider the use of community-based respite service. Such intervention would allow for continuity of care and is conducive to a wellness approach to support services. In some instances, respite is most appropriate in the home setting, an area not currently funded. Presently, when care givers need a break, institutional respite becomes a costly must.

Ms Baiden: Serving consumers through a centralized, independent and objective placement service will assist to ensure equal and equitable access to both information and placement. Directing all placements, for example, through placement coordination services will streamline the admission process for facilities, consumers and families. We wish to emphasize the consumer's right to choice when working with placement coordinators in seeking facility living.

1100

In order to fully ensure equity around access, eligibility criteria must be precise and consistent across the province, and regulations around admission to the facility must be concise and consistently applied. We are pleased to note that the regulations allow for an appeal process regarding eligibility for service.

VON recognizes the need for short-stay accommodation in each facility, as we recommend that this be utilized for respite in some cases and/or care during periods of exacerbation of illness.

VON supports the expanded role of placement coordinators and the availability of this program on a provincewide basis. In the districts of Sudbury-Manitoulin and Algoma, VON administers placement coordination service.

In concluding, VON wishes to emphasize our interest in long-term care reform and to acknowledge the government's initiative in consulting with communities across the province. We look forward to working with the government in planning and implementing an enhanced health care system which will provide a quality continuum of care within available resources.

Thank you for your time this morning. We are prepared to answer any questions you may have.

The Chair: Thank you very much for a very full brief. You touched on a number of issues. I think I should also note that we've had a number of VONs come forward, and I think probably everyone has said they'd be happy and willing to participate in a pilot project, so we note that as well.

We'll begin the questioning with Ms Caplan.

Mrs Caplan: I'd like to repeat the Chair's comments about your excellent brief and also acknowledge the important role that VON plays across the province. From my experience, your members and service providers have always lived up to the values that you expressed in your brief today.

I'm not going to ask a lot of questions, but what I would like you to do, however, is speak a little bit about the total quality management approach as it works and has been working the last little while. I know that VON has been a leader in moving to that new approach, and I'm very aware that the NDP had been opposed to the whole compliance management approach, for example, within the nursing home branch at the ministry. They've much preferred an intrusive government inspection model, which I think many people we've heard before the committee and experts agree is outdated.

I'm hoping that at this committee perhaps the policy option that was rejected will be reconsidered, and perhaps an amendment would come forward that I'd like you to speak to. If there was an amendment to this legislation which required accreditation of programs, coupled with a requirement that you had a total quality management program in place, do you believe that would give the kind of accountability that would be in the consumers' interests and in the interests of those who wanted to protect the public interest?

Ms Blunt: I certainly think that moving towards total quality management is also a much more cost-effective way of providing services, something that I think we're all fully aware of that needs to happen in our health care system. We can very often be providing a lot of services and programs and doing them very well. But unless we base our analysis and evaluation on these services and programs, on outcomes and consumer satisfaction, then maybe we're not doing the right thing. I think that's one of the areas that's most critical to total quality management. We can then find out if we're doing the right things for people. If we focus our spending on the right programs and services that enhance consumer satisfaction, the system in the long run will become much more cost-effective.

Mrs Caplan: You used a couple of words that I know were very deliberate because they are part of the whole total quality management approach, and that is, doing the right thing to the right person in the right place at the right time right away. Doing it right the first time, I guess, is the whole concept.

Ms Blunt: Yes, that's right.

Mrs Caplan: Could you just speak a little bit more about that? The reason I'm asking you to do this is that I'm hoping you'll convince the government that this is a better approach than the enforcement model with the inspector. The overall understanding is that inspectors are an after-the-fact intrusion and do not allow for the focus on outcome and consumer satisfaction and getting it right the first time. Have you had experience in that?

Ms Baiden: Particularly I like your use of the words "after-the-fact outcome." One of the key focuses of quality management is that it's a continuous process, it's ongoing, and it doesn't look at service delivery and programs being offered in the absence of some form of evaluation.

The other area, to add to what Antoinette has said to you around quality management and looking at consumer satisfaction, is not only to go to consumers to seek their satisfaction with existing services but also to identify gaps and close those gaps. So when we look to doing consumer satisfaction surveys, we look not only to the clients we serve but, for example, to the owners of facilities so that they have an opportunity to have input in terms of where they see areas for improvement, again, commenting on their satisfaction with existing resources and services available to them, but providing an opportunity to offer suggestions for improvement and where some of those gaps need to be closed. So very much in terms of the after-the-fact inspection, quality management through VON's approach is to look at just a continuous system of monitoring and evaluating how we're actually providing services.

Mrs Caplan: And you would be comfortable with the level of accountability if this legislation required a quality management program and made mandatory accreditation, whether it was for a facility or some body to look at the program that was in place, on the basis of outcomes?

Ms Blunt: Yes, I would certainly support what you're saying as far as on the basis of outcomes. The whole direction of total quality management is one that very much involves the consumer, and it has been noted by many

consumers across this province that they want more involvement. They want involvement in the decision-making process for what programs and services are to be offered, and looking at service provision from this perspective will truly give consumers the power that they need to be a full partner in the system.

Mrs Caplan: And enforcement models and inspectors don't do that, do they?

Ms Blunt: No, they don't.

Mr Jackson: Thank you for a very thorough brief. We're hearing the overall theme of limited time for response to the bill and the absence of guidelines in the legislation, but, "Trust us, it'll come out in regulations at some point," and maybe we should delay till we see the whole picture. We're getting that message from a growing number of front-line service providers and it's interesting and appreciated that you've focused in on that as well.

Could you share with the committee—and I wanted to ask this question of an earlier deputant—about the current role of placement coordination and how it's working and how you would see that changing, if at all? You offer a wide variety of services. There are some placement coordination services currently occurring in Sudbury, but that may change. Could you directly respond to how it's working here and how you see a change?

1110

Ms Blunt: In Algoma, VON has administered the placement coordination service for approximately 12 years, so we did have one of the earlier programs in operation. Prior to the existence of placement coordination, one of the problems was lack of information on how many people needed to access the system. Many people's names were on one or two different waiting lists at different facilities. There was a lack of knowledge by service providers and for government to be able to be able to determine how many people were awaiting placement for the various levels of care. Providing placement coordination provides a centralized area where people can access the system for long-term care facility placement.

Mr Jackson: I'm sorry.

Ms Blunt: Is that what you're asking?

Mr Jackson: No. We understand the process of placement coordination.

Ms Blunt: Okav.

Mr Jackson: You have a patchwork, with some of your VONs doing the placement coordination service and some aren't. Do you feel you're going to be removed from this responsibility and that some superboard of placement coordination's going to replace it? I see that two out of your four VON services are conducting placement coordination services. Is that the sole placement coordination service in the city of Sudbury? I don't know these things. That's why I want to know from you, who does placement coordination service in Sudbury and Algoma? It is you, according to this brief.

Ms Blunt: Yes. There is no other-

Mr Jackson: Do you see that changing?

Ms Blunt: Do I see that changing?

Mr Jackson: Have you had any discussions with the government about it changing? I was just wanting to get a sense of, do you think you're going to be the placement coordination service or do you not think you're going to be the placement coordination service?

Ms Blunt: I think that's a very difficult question to answer, given the day. I'm not really sure what the future will hold. I believe that the current placement coordination service as it is administered is an effective service. I feel the role of the coordinator does need to expand somewhat to meet all the needs that have been identified in Bill 101. I'm not really sure whether or not in the future it will be a part of VON. I can't answer that question.

Ms Baiden: In Sudbury, VON does administer the placement coordination service and we've been running the program for coming up to four years now.

Your initial question was, how do we see placement coordination service changing as a service? Not to defer your question on whether or not it will be VON that administers, in terms of how the program will change, right now participation through placement coordination service, particularly by facilities, is on a voluntary basis. In some of the noted changes in Bill 101, I guess one of the things we would support is that the participation through placement coordination service not be voluntary. I don't like to use the word "mandatory," but all facilities and individuals seeking placement would be coordinated through one central location.

The reason for this particular type of move really looks at some of the areas such as standardization so that we are looking at standard methods of data collection, data analysis and that this can be centrally looked at through the province so there's a better understanding and determination around the need for additional beds or decreasing beds. The system which in the past used to do some of that tracking on beds is no longer utilized, and in order to really have good information around bed utilization and waiting list pictures, we believe that it is critical that one service placement coordination service would well serve that function, particularly to have readily available information, and that there would be some very clear reporting requirements from placement coordination services into a central location so those data are available on an easily accessible basis.

Mr Owens: This is my first day on the committee, so I hope you'll forgive me if I ask you questions your group has already answered.

In terms of your comments with respect to total quality management, I think that in a Utopian society that would be the way I would like to go myself in terms of people proactively looking at issues with respect to care, to ensuring that residents are challenged appropriately with respect to activities and things like that. But I guess in terms of my experience with the group Concerned Friends, the seniors' group that monitors residential care facilities, it's their view that currently there are serious difficulties within the system.

How would you address those difficulties as they arose without having an inspection model? Maybe I'm misinterpreting what the total quality management approach means, but having an experience with what was called the internal responsibility system under the Occupational Health and Safety Act, people are basically allowed to do what they need to do until someone complains, so how would you intervene in a process before a resident was either hurt or perhaps wasn't given the appropriate level of care that was necessitated?

Ms Baiden: I'm not familiar with the group Friends that you've mentioned.

Mr Owens: Concerned Friends. It's a group of seniors that have been involved in advocacy for seniors. Perhaps it doesn't have a northern affiliate group, but it's been around for quite a number of years and has advocated on behalf of seniors in a number of situations in Toronto. When complaints have been made by residents, this group will become involved with the other residents and their families. They've acted as de facto advocates with the lack of advocacy legislation.

Ms Baiden: Just based on what you're saying and how I'm interpreting what you're saying, the total quality management approach would ensure that groups such as Concerned Friends would have systems and processes in place whereby it's not a cumulation of information or outcomes that is reported to them, and then it's, "Where do we go with this information?" or "Where do we turn to have assistance with our problem?" but rather, there are some systems and processes in place whereby there's a continual monitoring and collection of information to determine if in fact there are problems.

The group has an opportunity to be working with an advocate or perhaps problem-solvers so that they can jointly work together to address the concerns of the residents they represent. I don't know if I've understood Concerned Friends correctly, but I think many times we have systems in place that there is a location where complaints can be made, and then the question becomes, what happens to the complaints once they've been lodged? In a total quality management approach, there are very clear systems to ensure that when there are complaints or suggestions for improvement, feedback is given. There's a very clear direction with where you would go with that information so that there can be change, improvement made to existing systems.

Mr Owens: In terms of the regulation-making process that is currently taking place under this legislation, would you see a need for the government to perhaps make regulations regionally sensitive to northerners, for instance, in respect to the services that may or may not exist in the area?

Ms Blunt: One of the things we mentioned in our presentation that we would fully support is that there would be provincial standards to ensure that a certain level of services was available to all consumers in all communities across the province. We do recognize that you can't offer everything to everybody in the same location. I think we wanted to make this group today aware of the sensitivities

of the very large geographic diversity in northern Ontario, such that there might have to be additional innovative ways of service delivery to meet some of those needs. But what is essential right now is that basic services and some core programs and services are not available in every community throughout this province. That needs to be determined by the setting of provincial standards, and then we would move on from there.

Mrs Caplan: The standards would be the basis of accreditation?

Ms Blunt: Yes, they could.

The Chair: The parliamentary assistant had a couple of points that he wished to clarify. If it's not quite as clear, you may engage in your own questions with him.

Mr Wessenger: Thank you very much for your presentation. I always enjoy presentations from the VON because they're so well thought out.

First of all, I'd like to refer to your comment about deinstitutionalization. I'd like to assure you that no person is going to be forced out of an institution; that's not part of a policy. Secondly, with respect to the policy statement, it is expected out in the month of March, hopefully as early as possible. Of course, as you know, the local planning process of the DHC will determine the whole aspect of service delivery and also, in respect to the role of your placement coordinating service, that it will continue to be under your jurisdiction unless the local—it depends on, of course, the result of the multiservice agency model that may be evolved as a result of a local consultation.

1120

Mrs Caplan: We have a subtle change of translation for that.

Mr Wessenger: You made one other comment about the question of the respite care. The preferred option for respite care will be in the community; that will be the preferred option.

One last point is, in the bill there's reference to quality assurance, which apparently is not the right language, but there is a commitment to the concept of quality management, and the necessary amendments will be made in the legislation to ensure that. I can also assure you that certainly as far as the policy is concerned, we do believe in the compliance model. However, I would suggest that if the compliance model doesn't work, you do need some underpinning with respect to ensuring that changes are made.

Ms Blunt: Just one final comment: "Total quality management" is more than a change in language from "quality assurance." That must be stressed.

Mrs Marland: Exactly.

The Chair: I want to thank you both for coming. It has been noted in terms of the content of your brief and also in answering our questions. We very much appreciate your coming here this morning. Thank you.

I now call on the Victorian Order of Nurses from Sault Ste Marie, if you would come forward please.

Ms Blunt: That is me. What we did was, we joined together to provide a joint perspective from the north.

The Chair: Oh, you did?

Ms Blunt: Yes. Thank you.

The Chair: I'm sorry. I misunderstood. Mr Owens: We have another half an hour. Ms Blunt: We've almost used our full hour.

The Chair: With that, because the 11:30 group cancelled, I will allow each caucus, if that's all right with you. one more set of questions. I was starting to call it to an end because I thought we were going to have another submission Ms Marland?

Mrs Marland: Actually, Mr Chairman, I was going to raise a point of order. I'll wait until we finish the deputa-

The Chair: All right, Ms O'Neill? Is that all right? Sorry, do you mind?

Mrs O'Neill: I'm really pleased that this has happened. I would like to clarify something from the parliamentary assistant, though. There are two or three things he said that I'm not sure about. The respite care: Did you suggest that the suggestion that's been put forward this morning would not be considered because there's a preferred option, and would you explain that?

Mr Wessenger: No. I made no such suggestion. I just wanted to assure the presenters that although we're providing under Bill 101 with respect to the opportunity for respite care within the institutional setting, the preferred option from a policy point of view is for the respite care to be delivered to the community.

Mrs O'Neill: I still don't know the answer, but I guess that's okay.

Mr Wessenger: Perhaps I'll ask ministry staff, then. to respond.

Mrs O'Neill: Yes, I think that would have been better in the first place, probably.

Mr Quirt: As the presenters have pointed out, Bill 101 allows for respite care to be delivered by each longterm care facility for the first time, and funding arrangements currently are such that there's a disincentive to nursing homes and homes for the aged to leave beds open for the purposes of offering respite. Bill 101 allows us to have a respite care capacity in each long-term care facility.

But as Mr Wessenger was pointing out, that's only one of a number of ways in which respite care can be delivered. From our perspective, respite care is the objective of delivering service and respite care can be delivered to family care givers by a volunteer going in to allow a care giver to go out for an evening; it can be achieved by sending in a Red Cross homemaker for a period of time if other services need to be done in the home while care givers are away. The province would pay 100% of the cost through the health and personal support program delivered through the home care program.

As you're well aware, often a VON nurse going in for a visit allows a degree of respite, so depending on the circumstances clients find themselves in, and their families, respite care can be achieved by making respite care a valid reason for delivering the services of volunteers and other professionals in the long-term care system.

You would be familiar with a problem with the home care program currently, where the patient is the patient and the family situation can't, as often as would be advisable, be taken into account in determining what that family needs. So the objective is to make respite care for family care givers a bona fide, legitimate reason for the service system responding in as flexible a way as it can.

The Chair: There was a question back just on that answer. I wanted to allow Ms Blunt to comment.

Ms Blunt: I think it's encouraging that the government is willing to pay for respite. I just wanted to expand on something that you actually said. It is important to have respite in a cost-effective manner provided at the level of need of the individual. In many situations a volunteer, a health care aide or a homemaker is appropriate. There are other situations where family is looking after very chronically ill people or very high-level care family members in their homes. So when the government is looking at funding, it should consider a broad perspective of needs to meet the level of need of the particular person, and that could go as high as an RNA- or RN-level care.

At this point in time, there is no funding to support higher levels of needs of respite in the community and often these individuals, if their families can no longer support them, will end up being the more costly ones in an institutional setting. So when the government looks at funding respite, all levels of needs of individuals should be considered in order that their care at home may be maintained as long as possible by the family.

Mrs O'Neill: I am really pleased that we have got that issue so well explained from both sides.

I would like to say, in my opportunity, that I am very pleased with the tone of your brief. I like the statements and I think we can't say it too often, the reasonable risk that seniors have a right to take. You show, as Ms Caplan said, the deep respect for decision-making on the part of the consumer. I really think we have to continue to remind ourselves of that.

You express a fear that many of us have that this document is really leading towards further institutionalization in maybe insipid ways, and that is a concern.

You didn't say very much about the DHC, other than you approve of the role it will take in Bill 101. Can you give us anything from any of your own personal examples that would say how that's happening in your communities? That's my only question. Have you begun, I guess is what I want to know?

Ms Baiden: I can speak not on behalf but from my experience with working with our local district health council. Certainly we feel that the district health councils locally are well positioned to assume a leadership role in terms of coordinating comprehensive planning. In our area, through the long-term care committee, for example, the committee has undergone review in response to the government's decision that long-term care leadership would fall to district health councils and has looked at terms of reference in terms of committee representation.

Our district health council well represents a huge geographic area: representatives from Chapleau, Manitoulin Island, Espanola, Sudbury district east, the regional municipality of Sudbury. Particularly in the north, it's critical that all the various points of view are well represented and heard at the planning level so that there isn't duplication and there aren't certain groups that are left out or assumptions made that services can be delivered in such a way to meet the needs of a particular geographic area. I can't stress enough that geography in the north, particularly to the rural areas, must be considered in any of the proposals around long-term care services.

When we look at the core services that we've spoken to, we are clearly committed that those core services need to be in place across the province, and that would include as well the rural communities so that our rural areas are well served and will have the choice available to them around services.

The Chair: Ms Marland, did you have any questions you wanted to ask? No. Then Mr Bisson.

Mr Bisson: You raised in your brief, I thought, a point—let me take it from this way. What you're talking about is basically trying to find some way of ensuring some standards in regard to the whole question of care through Bill 101. Then there was a bit of a discussion between Mrs Caplan and yourself, and I thought it was rather interesting in regard to the whole question of, how do you ensure that standard levels of care are provided for within the community and within the care givers?

The discussion was around, well, there's a problem in having sort of the enforcer come in and tell you that you're doing something right or doing something wrong, because I think we all understand that as human beings we hate to be told we're doing something wrong, especially if we think we're doing everything possible in order to make it right. Unfortunately, the view sometimes of an inspector as to what's going on and what's actually happening may be a little bit different. I think we've all lived those experiences.

How would you see that kind of system being established, where you didn't have to do it through sort of an enforcement type of process, rather than having some sort of incentive process or something? I'm just curious about that.

1130

Ms Blunt: Under a system of total quality management, when you look at the development of standards, you would certainly involve a high percentage of consumers in developing those standards for programs and services.

I think an earlier speaker mentioned the role of the residents' councils. Residents who are residing in facilities would also have the opportunity to speak up in regard to the outcome of services and programs, to discuss with facility operators as to whether or not they feel the standards are being met from their perspective. So it's very much a joint initiative between consumers, professionals and government working together to ensure that the standards are met, but from the very beginning you have to involve the consumers in the development of the standards and gain from their perspective what services and programs are needed as core services in our communities.

Mr Bisson: I see that as the easy part of it. The difficult part, and I guess the one I'm struggling with, is, what do you do in those cases where something really needs to be done and for some reason it's not identified by the consumers, or maybe they don't want to identify it for some reason? It somehow slips through the system. What can you do in order to make sure that you have a system, that you ensure care, without having to do the enforcement thing? Because I have the same concern.

Ms Blunt: First of all, from my experience in working with VON in the community for the past 14 years, consumers are not afraid to speak up if they will be listened to, and I believe as we continue to empower the consumers, give them some of the responsibility in making decisions, that we will have that input. That's certainly not an area that I'm very concerned about.

Mrs Caplan: It might be helpful to Mr Bisson if you explained the fact that TQM involves ongoing monitoring and evaluation and feedback.

Mr Bisson: No, I understand that, I do, because we've had this discussion with nursing homes and Extendicare units within my own riding. There are cases where things will fall through the system, like, they'll slip through the crack, and that's one of the things the enforcement part of it is able to do. Anyway—

Mrs Caplan: Enforcement doesn't do that; enforcement is after the fact.

Mr Bisson: No. I realize that, but I just have—

The Chair: The parliamentary assistant and then Ms Marland.

Mr Wessenger: Just one quick question. I would like to know who you think should have the ultimate responsibility for ensuring that standards of care are maintained in the facilities. Should it be the facility itself, or should it be the government, representing the taxpayer, that has that ultimate responsibility?

Ms Blunt: There has to be something put in place to ensure that the standards are met, and I believe that can be measured by looking at the outcomes and also by putting something in place such as accreditation. I think that could certainly be one tool that could be looked at as far as measuring the outcomes in a total quality management system is concerned.

The Chair: Thank you again for coming before the committee. Just so our records are clear, I guess really for my own information, the VON in Algoma encompasses Sault Ste Marie?

Ms Blunt: Yes. Sault Ste Marie, the district of Algoma.

The Chair: The whole district, fine. Again, thanks very much for coming before the committee. Ms Marland.

Mrs Marland: Mr Chairman, it's my understanding that committee proceedings come under the same rules and etiquette as any proceeding in the chamber, in the House. Am I correct?

The Chair: I believe so.

Mrs Marland: I think that if the clerk were here, he'd probably—

The Chair: Probably you're able to be a little more informal at times in a committee setting, but I believe in essence it goes on the same—

Mrs Marland: —on the same, but it's my understanding that the same rules abide.

I've been in the Ontario Legislature for eight years now, and some time in the past two years, for the first time, we had some government members who were using their telephones during the proceedings in the House. Speaker Warner made a ruling that those kinds of equipment were not permitted in the House. He made that ruling, which I totally support.

I just have to raise the question, Mr Chairman, that if every one of the committee members sat here with laptops in front of them, how intimidating or uncomfortable that would be for our deputations before this committee. So I am surprised to see one of the government members this morning sitting here using a laptop computer during the hearing proceedings.

Mr Bisson: Can I just clarify, because I did ask—

The Chair: Just one moment, please. Does that conclude your point?

Mrs Marland: That's what I'm asking you to make a decision on, whether that's acceptable.

The Chair: Okay. Mr Bisson?

Mr Bisson: I was just going to say I asked, coming into the committee meeting, the Chair this morning for the permission, and it has been allowed in other situations on committees that I've sat on. Normally you ask the Chair and the Chair makes a decision, which I did this morning.

The Chair: I am informed that the Speaker did indicate that laptops should not be used by members during committee hearings. So I was not aware of that, but perhaps I could ask all members to abide by that ruling. Mr Bisson.

Mr Bisson: I will do it, but we should move to the 21st century as quickly as possible.

The Chair: It is certainly a question that can go forward

Mrs O'Neill: It has been ruled out of order in the federal chamber as well.

The Chair: In any event, I understand that that is so, and I'm sure the honourable member will abide by it.

Before we break, I just want to thank everyone who has been with us this morning, both the participants and those who have been watching the proceedings. We will reconvene at 1:15 here, okay? Reconvene at 1:15. The committee now stands adjourned.

The committee recessed at 1137.

AFTERNOON SITTING

The committee resumed at 1302.

The Chair: Good afternoon, ladies and gentlemen. I call the afternoon session of the standing committee on social development to order. Again, we are continuing in Sudbury.

ONTARIO FINNISH RESTHOME ASSOCIATION

The Chair: Our first deputation this afternoon is the representative from the Ontario Finnish Resthome Association. We have the briefs; they're just being circulated. Perhaps you would be good enough to come forward. Welcome to the committee. Thank you for coming over from the Sault. We appreciate your making the time and effort to do that. If you'd be good enough to introduce yourself for Hansard and the committee members, then please go ahead with your brief.

Mr Lewis Massad: Thank you, Mr Chairman. My name is Lewis Massad. I'm the executive director of the Ontario Finnish Resthome Association in Sault Ste Marie. Our association—this is included in your brief—is a nonprofit, charitable organization. It offers services to seniors within Sault Ste Marie. We operate a recently opened 60-bed extended care nursing home facility, a 111-unit charitable institution which serves aged people, plus as well a 132-bed seniors' apartment complex.

I'll keep my presentation fairly short. You have our brief in front of you, which includes an executive summary.

To start with, our association and our board of directors offer support towards Bill 101. Certainly, it has a major directive that will improve the care offered to seniors throughout the province. The major thrust is to standardize it and that is welcomed by our facility.

We do offer some concern at this point. The concern is that we hope the Legislature will ensure that adequate funding is provided vis-à-vis the levels of care funding and hopefully that the levels of care aren't going to be adjusted to reflect the dollars available, because with that will only come continued shortfalls of funding for all facilities within the system.

Of significant concern to our facility, which I would like to address, is the principle we support that there is consistent application to revenues, to operations between charitables, homes for the aged and nursing homes. In reading through 101 and all the various pieces of legislation, there's one major flaw that we find, and that's that in the future accommodation costs will be standardized throughout the province. However, the flaw is that one of the most significant costs facing these three facilities in terms of accommodation is not standardized, and that's municipal taxes.

Our facility is very concerned that as it stands right now, nursing homes, both for-profit and not-for-profit, will continue to be found taxable for municipal realty and business taxes, whereas homes for the aged, municipal homes for the aged, and as well charitable institutions will be found tax-exempt. Realty taxes account for the largest non-controllable accommodation cost for any facility. Other items such as housekeeping, maintenance, those items are controllable and variable, but this is a non-controllable item. Our facility, if anything can come out of my presentation today, would ask that the Legislature give the utmost consideration to that fact, that equality is to be provided, and that's the principle, for these three types of facilities. But you have to look at standardized costs, and that is one item that is of particular concern. There are many other items that are variable, such as, within northern Ontario we face higher utility costs, as an accommodation expense.

The principle of standardized accommodation costs is flawed unless there is some allowance and some consistency given towards—I go back to municipal tax exemption status. That is the premier concern our facility holds towards Bill 101 at this point.

Another item I would hope is ensured by the Legislature and the Ministry of Health is that levels-of-care classification is sound. It will only be sound if it is undertaken on an annual basis. As you'll identify in levels-of-care funding, which I believe is page 2, unless the levels of care classification which took place in September-October of this past year happens on an annual basis, inequities will again creep into the system. That must be a requirement with levels-of-care funding.

As well, many of the other aspects that I speak to on levels-of-care funding are supported. Truly, over the years there has been a hodgepodge of rates and fees for all residents across the province in the different types of facilities, and hopefully that will be rectified.

Our facility supports, as well, the concept of service agreements. It's nothing new to the nursing home industry and we'll continue to work with the Ministry of Health when service agreements are put in place.

As well, we support the concept that non-profit nursing homes will be provided capital towards their operations. That is new. It's certainly welcomed. Until we see what the actual funding arrangements are, as identified in the regulations, it's difficult to comment further, but the concept is clearly supported.

1310

In terms of the coordinated facility access, residents within our complex have offered some concern that they may lose the option of choice as it is identified currently. Facilities such as the Ontario Finnish Resthome Association, which has been built upon and is owned and operated by an ethnically operated association, have some concern that at least until we see what's in the regulations, it's difficult to offer total support to the placement coordination services, and the ability of any facility to reject an admission is yet to be identified.

As well, we hope that through the placement coordination services, organizations which offer services to seniors that have been based on an ethnic background will not lose their ability to maintain that ethnicity as placement coordination service will govern and manage the admissions process.

I express concern from some of our residents to date as to the accommodation cost per diem that they will be faced with, not knowing how, if any, there will be income testing. They're concerned with that process, just being in the dark at this point in time. I just pass that on as well from our residents' council.

Another item as it relates to our facility and probably many others is the concern that the requirement that dictates how much a facility can charge a resident will be governed by statute law. However, nowhere in Bill 101 or within the various pieces of legislation does it address the requirement under statute law that the residents must pay for their accommodation cost. That, as well, is a matter of contract law between the facility and the resident or the resident's family or responsible person. That is of concern because under contract law it's very difficult, it's very expensive and it's an embarrassment many times for many administrators to have to take a family to court, while the resident is still in the facility, to secure funding.

As well, if it continues, then our facility would hope that greater flexibility be afforded administrators, that when there is a breach of contract that they will be able to act appropriately.

In terms of enhanced accountability, support is given towards the requirement that all homes provide resident care plans. Certainly, a resident care plan in any facility is the basis on which care is provided. Within our complex we have striven, and it is a policy of our board and it is implemented at the staff level, so that our care plans not only reflect the current day-to-day needs of the residents—what do they need today?—but as well our care plans reflect what we can do for them tomorrow to make the next day better. That's an important principle that as well should be written one step further in Bill 101. It's not just day-to-day maintenance, but ongoing and futuristic and proactive. Resident care plans are important. That has been in place in our facility and we will continue to work towards the betterment of the care for all our residents.

Support is as well given towards quality assurance plans and the added powers offered to inspectors. Within our complex we've only been in operation for about two years. We've had the Ministry of Health inspection branch in, I'd say, at least six or seven times, and each time we have welcomed them. I feel that facilities that are non-supportive of that concept—if their administration is open-minded and progressive, they would utilize the expertise offered by inspectors as they come in. They see many different facilities across the province and they're not coming in heavy-fisted. Many times they come in and they leave us more information than they've actually found on non-compliance. We support the added inspection powers offered to inspectors.

In summary, Bill 101 is a good step forward. We certainly would hope that it's just a start to make all these three types of facilities standardized. I would hope that the utmost urgency of the Legislature be given to repealing the various acts that govern the three types of facilities and that for lack of a better term, maybe one long-term care facilities act be put in place. It's a rather piecemeal approach as it stands right now, but yet it certainly is a welcome start.

Just to summarize, the Ontario Finnish rest homes facilities' major concern is that of consistency as it relates to accommodation costs, and that being that non-profit nursing homes, which are a support of the current government and a direction I believe it wishes to proceed in, be afforded the same tax-exemption status that is currently received by homes for the aged and as well charitable institutions and homes for the aged.

Thank you for your attention. I can address any questions you have.

The Chair: Thank you very much for the presentation and for a number of specific issues that we haven't necessarily had addressed before the committee up until this point. We'll begin our questioning with Mr Jackson.

Mr Jackson: This brief contains several new areas we've not dwelt on at length, so I want to say up front that we appreciate your long trip from the Sault and the information you've brought us.

Mr Massad: Thank you very much. That rather concerns me. These are very broad issues that we would hope would have been addressed previously.

Mr Jackson: Well, they have been, and certainly your three main points have been persistently and consistently. but there are ones that you raise are rather new for someone who's been on this committee at length.

On the issue of municipal taxes, I guess I would like to leave with the parliamentary assistant and/or our researcher to determine—I thought the legislation on municipal taxes was flexible enough that they could receive and review an application for exemption because they were charitable, non-profit. I know the distinction and the language of the legislation as it relates to homes for the aged which are municipally run. That's a given. But I'd like further information, because I think it's a very valid point, and I'd like to pursue it.

There's no need for further comment there perhaps, but the other one was the notion of breach-of-contract responsibilities, and perhaps in the presence of the deputant we might ask legal counsel for some clarification. Is there anything in this bill or these bills which purports to strengthen the ability of the administration to—for the item raised, the breach of contract. The bill speaks at length to the added powers of the province in enforcement and removal of licence, but I think if we use the rent control analogy, every time a tenant skips and doesn't pay, the other tenants have to pay.

We certainly don't want an arrangement where the integrity of the legislation is diminished because we haven't looked at this issue. Perhaps you could let us know if there's anything in this legislation which addresses the concerns about strengthening an administrator's right or ability of accountability with its revenue base.

The Chair: Before we go on with your questioning, and just so it's in Hansard then, can those be looked by the ministry? Did you want an answer now or just that you wanted that—

Mr Jackson: No, I think my direction was clear. The one, I believe, takes it partially out of the realm of legal counsel, and I have left that part with the assistant director

of legislative research. I believe legal counsel can respond directly to the question which flows from the bill, so I'd be comfortable getting the one answer, but on the other one, I'm sure, we'll get additional information, because it really is a Municipal Affairs and Revenue issue.

1320

The Chair: We'll get clarification from legal counsel.

Ms Czukar: No, there's nothing in the bill that specifically requires residents to make payment to the home, because it is a matter between the home and the resident. The only provision in the bill that addresses the issue of what the charges are to the resident is the provision that doesn't allow the operator to charge over a certain amount, which will be the maximum amount for the copayment and for preferred accommodation. So it's true that it is a matter of contract law between the home and the resident.

You didn't really ask this, but I might go further to say that the reason it's that way is that the only way it would be meaningful to put it in the statute to require residents to pay the home is if the province was going to get involved and then enforcing that in some way. That's not currently the situation and we weren't instructed to change it. So it's basically the way it operates now, which is that it's a matter between the home and the resident. It maintains that situation.

The Chair: Have you any follow-up question or does that clarify?

Mr Massad: The only aspect, then, is that if it is not to be written into the bill, as I had suggested, that greater flexibility through the bill be afforded to administrators to respond to residents or to residents' families that are in arrears—it's a very awkward position when you have a resident that certainly is \$8,000, \$9,000 or \$10,000 in arrears without going through the court system. Many administrators just don't want to discharge residents because of that. It's not great publicity.

Mr Wessenger: I might just follow that up and ask you if you have any suggestions for the committee on how this might be dealt with, without having to bring the province into the enforcement aspect, some flexibility that will allow you to have a greater ability to collect.

Mr Massad: Under the current Nursing Homes Act, the discharge of a resident can only happen if the administrator can find alternative accommodation for him or her. That's the only other way. Otherwise, we spend many hours in the court system to try and secure ongoing moneys as a result of their breach.

Mr Wessenger: Do you have this as a problem existing right now?

Mr Massad: Absolutely, and it's not just one resident.

The Chair: Mr Jackson, you may continue.

Mr Jackson: In that vein, we now are injecting into this process a placement coordination service which ultimately the home would have to fall on the mercy of in order to remove one resident to another facility because of his or her inability to pay. There is a role that affects the financial circumstances of the institution, and by extension all the remaining residents, by virtue of the gatekeeper

who can maintain the blockage or the non-removal of the individual. That strikes me as an appropriate role for the government since it will be controlling admissions and movements within institutions as the circumstances regarding their acuity and their financial matters change.

I wish only to state that for the record. I've heard clearly from legal counsel what her position is. Just being familiar with the Nursing Homes Act, I was rather concerned that you can essentially leave a non-paying resident there at the peril of the financial integrity of the institution, and yet we are mandating levels of care and other aspects of the operation in the absence of their ability to pay.

I don't have the answer at the moment. I just wish to bring to the parliamentary assistant's attention that we have a catch-22 here, which we're placing nursing homes in. That perhaps should be addressed while we have these bills open in a legislative setting when we can amend them, because once they're closed we're not going to have much of an opportunity to change them.

The Chair: I have Mr Wessenger next, who may also have something further to say on that point, I'm not sure, but you have the floor.

Mr Wessenger: Thank you very much for your thoughtful presentation. It's quite true that you have raised some points that haven't often been raised or pressed. I'd like to explore a little further this whole question of the non-payment by the resident. As you say, right now you can only discharge a resident if you find another place. Would you want to see the legislation amended to give you the right to discharge for non-payment, just an absolute right in the sense that this would give some flexibility in trying to negotiate with either family or someone else a method that would secure payment of the payments that are obliged to be made?

Mr Massad: I think if it's written into the bill, certainly in discussions with families that are in significant arrears, and discharge as a result of non-payment is an allowable consideration, that we can discharge, then yes, I would welcome that concept.

Mr Wessenger: I'd also like to add some clarification with respect to your third point about funding formula and per diem amounts for resident programming and activation. I'm going to ask ministry staff perhaps to clarify that point for you.

Mr Quirt: The presenter is quite right that at this point in time the government hasn't indicated to long-term care facilities precisely what the average per diem for long-term care facilities will be. It hasn't gone further to divide that per diem into the three categories the funding formula covers. We'll be in a position to do that once the estimates process confirms for 1993-94 what funding is available for long-term care facilities, in other words, what the base of the program is, to which \$206 million would be added.

It's our hope that in mid-March we'll be meeting with our funding focus group, a group of people who helped us design the funding formula and looked at costs among the three categories, to show them the funding available and how that works out on an average basis and to propose to them how it might be divided up among those three categories. We hope some closure can be brought to that as soon as the estimates process confirms how much funding is available for the program in the coming fiscal year.

Mr Massad: Thank you.

Mr Wessenger: I think that's all my questions.

Mrs Caplan: My first question is, what you just heard, does that give you any comfort in your concern?

Mr Massad: There's comfort that, yes, it's being looked into. If there's any concern, it's that the government may be going at it in the wrong direction, that it would be adjusting the formula based on the amount of dollars available rather than saying, "This is the level of care that's required throughout the province and this is the amount of hours or time or dollars," or whatever you want to call it, "that we expect to be provided," and then establishing the formula. That's a concern there.

Mrs Caplan: That's very helpful and I think a very important insight. I'm also familiar, as you know, with your association and with your homes. It's nice to see you here and to be able to say that I think you provide an excellent model for the provision of care in your community.

One of the things that you didn't mention—I hope I didn't miss it—is that this legislation does not take into account, by statute, the multicultural, linguistic requirements or choice for individuals as they make the selection. We've had some discussion about an amendment or a statement of principles that have been suggested that could be enshrined in the legislation or, it's also been suggested, by regulation, which would embody the principle of consumer choice and sensitivity to the cultural and linguistic environment that the individual would want to choose, as well as the need for appropriate care.

Do you have any comment on that? I know you serve a specific community in meeting those needs.

1330

Mr Massad: We serve a specific community, although our facility has never put a fence around it. Only approximately 45% of the residents within our complex are of Finnish background. We would hope that as a Finn requires care in the community, the placement coordination services would be sensitive to that need, and possibly through the amendment that you spoke of that could take place; flexibility would be given to them to allow for that. I'm not just speaking for the Finns. I'm speaking for many of the other ethnically owned facilities throughout the province.

I think your principle is sound, that if you're looking at it in a global sense, the placement coordination service be given that flexibility in its mandate. Certainly, speaking to many families that come and approach me, either in the malls or wherever, about entering a complex or institution, having to institutionalize a family member, the best advice I can give them is that in our municipality we're very fortunate. We have an excellent place coordination service, and for many of those residents, for the lack of a better term, one-stop shopping is the way to go. I was really surprised that they're not all throughout the province.

Mrs Caplan: I know it won't surprise you, but what we've heard virtually everywhere we've been is that where

there is a placement coordination service in place, everyone who's come, in the places we've been so far, has come to the committee and said: "We think we're unique. What we have here really works and it works well." Where we've heard fear expressed has been in those communities that don't have placement coordination services. I think the suggestion of an amendment, as far as the principle and the mandate of the placement coordination service is concerned, that was suggested by a placement coordination service, perhaps would give comfort to those who don't have them and act as a reminder for those that are already functioning under exactly that method.

Mr Massad: Exactly.

Mrs Caplan: So you'd support that?

Mr Massad: Yes, I would. We have an excellent rapport with our placement coordination service in Sault Ste Marie and it recognizes the ethnicity issue informally. That is not to say though, that people don't change, and attitudes may change, but if it is written in the amendment you speak of, it's certainly welcomed.

Mrs Caplan: One more question, or is time up.

The Chair: I'll give you a very short final.

Mrs Caplan: It's a two-part question. First, do you have in place a quality management program within your facility, because you mentioned the good relationship you have with the ministry?

Mr Massad: Yes, we do.

Mrs Caplan: The discussion has been here that where that good relationship takes place and where there has been—are you voluntarily accredited? Are you part of the accreditation program as well?

Mr Massad: At this present time, we are not an accredited facility. We're required to be in place one full year. We had some change of our senior staff and the timing just didn't allow for it. Although speaking to the current inspector who came, she said that her estimation would be that we would receive at least a two-year accreditation status if we were to apply. It's a very expensive process for facilities to go through. I've recommended to our board that we not become accredited until we see the total dollars that we're going to be working with in the future, and if it's going to be requirement as a part of quality assurance that you become accredited. I'm being rather cautious at this point.

Mrs Caplan: We've been talking here at this committee about an alternative to the enforcement model and that this alternative would be accreditation plus mandated quality management programs. Do you have any problem with that?

Mr Massad: No.

Mrs Caplan: Thank you.

The Chair: Thank you very much for coming over from the Sault today. I'll echo Ms Caplan's comments about your association. I certainly enjoyed my contact with them. You do a wonderful job in different parts of the province, and we thank you very for coming today.

Mr Massad: Thank you very much. I'll stay till the end, and if anybody has any questions, especially as it relates to the municipal tax issue and how that is affecting our facility and what the province to date has offered to our complex, I certainly would welcome any discussion. I thank you again, and hopefully you'll consider our brief in your deliberations.

ROYAL CANADIAN LEGION, BRANCH 23, NORTH BAY

The Chair: For committee members, we're going to move next to the representatives of the Royal Canadian Legion, and I would ask them if they would be good enough to come forward.

The representation for 1:30, the Algonquin Nursing Home, is going to be done by the Ontario Nursing Home Association, region 1, which is going to read the brief from the Algonquin Nursing Home. The people or person who was to come to do that was injured this morning—I gather it's not a matter of life and limb—and is unable to be with us. They have made these arrangements. We thought we'd take the Royal Canadian Legion first as they were here, and I believe one person is going to be making his way back to North Bay and the weather is not the greatest.

May I say first of all, gentlemen, that we welcome you to the committee, and if you'd be good enough to introduce yourselves for the committee members and for Hansard, then please go ahead with your presentation.

Mr William Sexsmith: Thank you very much, Mr Chairman. I'd like to introduce myself. My name is Bill Sexsmith. I am the provincial service officer with the Royal Canadian Legion with offices located in North Bay, Ontario, and at this time I'd like to introduce my colleague to my right, Mr Paul Richmond, president of Branch 23 of the Royal Canadian Legion, also from North Bay, Ontario.

We have distributed, Mr Chairman, with your permission, a copy of the brief. I realize our organization has already been in front of this committee on two other occasions, so with your permission, we will go down through the brief outlining some of our concerns for the north. We have strayed a bit from the original brief.

The Chair: That's fine, and I think having the context of the north would be very helpful for the committee. Please go ahead.

Mr Sexsmith: Thank you, Mr Chairman, we don't want to be repetitious.

I would like to just enter, for the purposes of Hansard, the background. You are no doubt aware of the Royal Canadian Legion's national community involvement. Our main concern is still, after 67 years of existence, the veterans' age, knowing our average age of World War II veterans is 71 and the Korean veteran is 60ish. Our mandate remains the same: veterans service.

The difference in our level of service is not declining; it is in fact growing exponentially with the veterans' increasing age. In 1990, the Legion provided \$5.5 million of support to needy veterans, and another half million volunteer hours have gone to veterans, ex-service personnel and their needy families.

With that, I'd like to pass over on to the next page. You've already heard our information on the estimates of Ontario command. I'd like to skip over veterans' care. I believe you're already well versed on that as well as concerns regarding long-term care and legion care housing projects.

I would like to start in at the closed beds at Sunnybrook. We would now like to refer to closed beds at Sunnybrook Medical Centre. We recognize that Bill 101 does not apply to chronic care and the closed beds at Sunnybrook in K wing are chronic care beds, but we wanted to ensure this issue is raised in the context of long-term care. The 45 priority beds for veterans in K wing have remained closed for over two years after assurances that the situation was temporary.

Long-term care beds in northern Ontario: We now would like to take a few moments to talk about the priority access beds which are not being used but were guaranteed.

We in northern Ontario strongly recommend it is now time to consider the feasibility for the reassignment of the unused priority access beds to northern Ontario communities. This would serve a two-fold purpose:

(1) There is a need for veterans and/or their dependents to have close proximity to hospital care and their loved ones as opposed to travelling hundreds of miles, for example, from Hornepayne to Toronto, to receive care.

(2) Every community has been exposed to a bed closure in one form or another, and the reallocation of these beds would reopen closed beds for long-term care, which would also be of benefit to the local medical community.

1340

Possibilities are municipalities that already have high level of treatment services such as North Bay, Sudbury, Timmins and Sault Ste Marie. The transfer of the London Phychiatric Institution patients to Parkwood Hospital resulted in a reduction of the availability of the priority access beds in Ontario. These were beds that were formally available to the veterans of the community which were set aside for the use of the transferred patients. We would like to see consideration given to the transfer of these unused priority access beds to northern Ontario.

We would now like to refer to the coordinated placement services. Our organization remains concerned that the right of veterans to be recognized and receive all levels of care authorized by the veterans care regulations might be jeopardized by Bill 101. The veterans health care regulations provide for residential and nursing home care, and partial funding of these cares is provided under the veterans independence program administered by Veterans Affairs Canada for certain eligible veterans.

We want to ensure that the admission policy will continue to provide for social admissions and necessary adult residential veterans.

Finally, the Legion is concerned that additional budget restraints may result in further erosion to veterans in Ontario. We would like to establish a commitment by this government to ensure that this special group will be protected from future restraint measures.

We in the legion in Ontario are committed to the prevention of the closing of any veterans' long-term care beds while simultaneously requesting the expansion of longterm care facilities for those who have earned the right to access to the best hospital care. The Sunnybrook K wing situation must not happen again.

Our organization extends its thanks to you for your consideration of this brief.

I understand, Mr Chairman, that there were questions and answers given in the other two briefs that were presented, and we will, if at all able, try to answer any questions this committee may have.

The Chair: Fine. Thank you for the brief. I think you're the third or fourth group from the Legion who has come forward, and we're glad that you have. We'll begin our questioning with Mr White.

Mr White: Thank you very much for bringing forth these issues and for so well representing your membership. As the Chair mentioned, this is the third presentation from the legion. We'll have another one tomorrow evening in Ottawa.

On the the Sunnybrook issue and the chronic care point, the provincial president spoke with me,and we were able to secure a meeting with the senior ministry officials. This would have been about a month or so ago. I don't think the issue is dead and you have to keep on plugging, but thank goodness there are people like you doing that.

Mr Sexsmith: Thank you very much.

Mr Hope: I just want to go to the one about the longterm care beds in the north. How would you do that? How would you allocate those beds? Would you allocate them to a specific home or allocate them to a certain region or area? I'm just curious how you'd do that because there would be a number of facilities wanting these beds and I'm wondering, how will we control that?

Mr Paul Richmond: If I may, I think our expertise does not lie in the field of allocation of health care; I think our expertise is in coming to you people and saying we want the health care.

We do know, and I'm sure you people are aware, that there are numerous beds that have—transfer payments have been made for many years by the Department of Veterans Affairs and the beds are not available to veterans. These beds are closed, they're inactive, call them what you will. Our concern is that these beds be reactivated. They're being paid for. Let's put them back in place and let's put them back in the communities where the veterans and the veterans' families have access to them. It is ridiculous to continue to contemplate people travelling from Hornepayne, Hearst, Kapuskasing, Sturgeon Falls as a matter of fact, to London, Ontario, to visit a person who has been in bed for many, many years.

Due to the budget restraints that we're all working under, we know that beds are being closed. The possibility of some of these beds being reopened in medical facilities in the north and being assigned as veterans' priority beds is not an unrealistic request. The money's there, you're being paid. We really feel—let's be down-to-earth about it without being a little bit facetious or anything—that these are people who have earned the right to the best of hospital care. They're the people who have earned the right for this

commission to be established. They deserve the best possible health care that can be given.

Mr Hope: We have to keep consumers sensitive around it, so I guess we couldn't lock it right to a facility. We'd have to make them kind of floatable so that if the consumer chooses to go to a certain area, who is a veteran who wants to go to a certain nursing home or home for the aged or charitable home, it has to be flexible enough to allow that veteran to have the sensitivity of choice.

Mr Richmond: I believe there's somewhere in the neighbourhood of 1,400 priority beds allocated to Ontario; I think it's 1,365 or something like that. There are roughly about 200 not being used right now. If a percentage, even if you tied it into population, were assigned to northern Ontario—for example, say 30, a percentage, could be put in the Sudbury communities, a percentage in Timmins, a percentage in the Sault, North Bay, Huntsville, someplace where the veteran would have much more access to his family and his family would have more access to the veteran. That's our main concern.

Mrs O'Neill: Yes, gentlemen, Mr Richmond and Mr Sexsmith, thanks so much for coming. I think the advice you were given that you must continue to pursue your issue is very well given, and I'm glad you've accepted it. I just want to say that the veterans always, I think, make us stop and think. First of all, you have not forgotten those who have preceded you in death, and you certainly haven't forgotten those who are in need around you. Sometimes that's not just veterans, but the youth in the community as well. I don't think we can be reminded of that any better than through your efforts.

I think you have given the government a very interesting challenge. I'm very happy you've done that. I think we are, all of us on this committee, working in a vacuum regarding chronic care and the chronic care beds. The chronic care study, I feel, should be very much a part of our own deliberations. As you know, we do not have that yet.

You skipped over veterans' care, and I presume the reason you did—I couldn't resist reading—was that you are now in discussion with the Ministry of Health on the issue. Could you say a little bit about Sunnybrook, the unassigned priority beds? Have you been able to bring that forward in any discussions to this point at any level with the Ministry of Health, or is this the first time you're basically presenting this as a need for the north?

Mr Richmond: I believe you're speaking of the Sunnybrook beds that we would like to see—

Mrs O'Neill: Yes, the area you spent most of your time on in your presentation.

Mr Richmond: We don't advocate taking the beds away from Sunnybrook itself. The MPP on my left indicated that he had met with the provincial president in the continuing discussions on the reopening of K wing. I'm suggesting that there are additional beds around, and if those deliberations to reopen the beds at Sunnybrook are unsuccessful, then maybe the assignment of those beds might be to the north. But there are other beds in Ontario right now that are being paid for that without touching the

Sunnybrook situation, very well could be reassigned to the north

Mrs O'Neill: Have you begun discussions at any level with the ministry or indeed with politicians on that particular issue, or is this the first time you're presenting this challenge?

Mr Sexsmith: If I could answer that, the veterans' affairs committee of Ontario provincial command are in the midst of discussions with the Ministry of Health on the 45 beds in Sunnybrook.

Mrs O'Neill: I just want to say that there's one area I don't think you've highlighted enough, and maybe you will in your continuing discussions: I think the spousal support that veterans have had throughout their lives is somehow also overlooked if we do not bring the priority access beds to the communities where they're needed. Often two people, particularly in the age groups you're talking about as average age for veterans now—I have one personal case in mind. It's most unfortunate that the spouses can't even be in the same city, and how hard that is on the families, let alone on the two individuals who have sacrificed quite a bit in their lives to this point. So perhaps you'd like to highlight the whole family structure in your presentations as you continue them.

Mr Sexsmith: I think that's going to be addressed tomorrow evening in Ottawa, partially anyway. Of course, we tried to touch on it here by bringing forward the point that we would like to see a redistribution of hospital beds here in the north, which of course would bring the spouse and/or dependants closer to the veteran.

Mrs O'Neill: Thank you so much for your time. 1350

Mrs Marland: We often sit in this committee and hear the government members address deputations as Brother So-and-so and Sister So-and-so. I feel, as a member of branch 82 in Mississauga, that I'm going to say Comrade Sexsmith and Comrade Richmond—indeed, with a great deal of pride, as the daughter of someone who gave his life in the Second World War in the Royal Navy.

Interjection.

Mr Jackson: We know "comrade" means something different to you.

Mrs Caplan: When you say "comrade," it has a different connotation.

The Chair: Order, please. We have harmony.

Mrs Marland: I realize there could never be enough said about the contribution of our veterans and there can never be enough said in complimenting the work that is ongoing with the Royal Canadian Legion and the fact that you are here doing something that isn't easy to do. I know can be difficult and somewhat intimidating. You're both very fine examples of people who are committed and do continue to serve.

I found it very interesting to hear one of the government members, Mr Hope, talk about sensitivity of choice, because that is something we as Progressive Conservatives have been talking about for a long time while we've been

trying to protect the private sector in the provision of nursing home beds and retirement homes.

Of course, this becomes even more acute as a problem when you get into the north and the east and the west extremities of this province, and the further you get away from the densely urban areas. It's fine for a government member to talk about sensitivity of choice when they're doing everything they can to put the private sector out of business. They want nothing but non-profit beds, which doesn't mean that it actually costs the government or therefore the taxpayers any less; in fact, in a lot of situations, as with the provision of other services, such as day care, it ends up costing the taxpayers more.

But to focus on what I think is the sensitivity of choice is to say what Ms O'Neill was saying, which is that choice has to address where the beds are available for the families to do their continuum of visiting. I guess I have to say this: I don't have any faith in the government's ability to listen and negotiate, or else we wouldn't, after all the public hearings around the province on this bill when it was in a discussion paper form, have ended up with the legislation we have before us currently. It obviously chose not to listen.

It's pretty difficult, isn't it, for us as non-medical people to understand really what the difference is between long-term care that could have included chronic care beds and doesn't in this legislation. In sharing the concern you have for the example of what has happened with Sunnybrook since this government has been in office. I want to ask you whether you could have designated beds or some kind of guarantee that beds would always be available where they would need it-in your case you're speaking for the north, but in these more remote areas of the province, if we could have guaranteed, even a single bed. We were talking earlier this morning about respite beds. In your discussions with the government, have you heard whether that was something it would ever consider, so that there was always the security of knowing that the surviving spouse and other family members, who may well be adult children at this point, would have access to keeping their loved one close to them?

Mr Sexsmith: I don't think to this point it has entered into any of the discussions that Ontario Command is presently having with the Ministry of Health, but it certainly is a point that is intended to be brought forward in the ensuing discussions that Ontario Command has with the Ministry of Health.

Mrs Marland: Maybe we could ask our permanent—I'm a substitute member on this committee today, but maybe we could ask our permanent members from our caucus on this committee to see if there is a way of securing that this is addressed on behalf of the veterans of this province, that it could be addressed in the regulations which will follow the legislation, or if we could possibly get the government members to support an amendment that we might like to make, to make sure those concerns are addressed in the legislation itself. Certainly, Mr Jackson and I will give you our assurance that we will pursue that.

Mr Sexsmith: Thank you.

The Chair: Thank you very much for coming before the committee today. As you noted, we are meeting in Ottawa tomorrow and will have the provincial command.

Mr Sexsmith: Thank you very much, Mr Chairman and committee members, and for those whom it applies to, thank you, comrades.

ALGONQUIN NURSING HOME ONTARIO NURSING HOME ASSOCIATION, REGION I

The Chair: Perhaps I could then ask the representatives from the ONHA, region 1, and the Algonquin Nursing Home—I may have expressed that incorrectly in terms of exactly what is going to happen, but perhaps you would be good enough to explain to the Chair and to the committee members. We want, first of all, to welcome you to the committee, and if you would be good enough to introduce yourselves and then explain the nature of the presentation, certainly I would be grateful.

Mr Dennis L. Boschetto: Thank you very much, Mr Chairman. In the interest of time and not repeating items that would go through both presentations, we sat down over lunch time and have combined the two. Vala Belter, who is the representative from the Algonquin Nursing Home, was going to be here this morning, and as you were told, was injured, it was an eye injury and she couldn't drive to Sudbury today, so she faxed us her presentation and asked us to present it on her behalf.

My name's Dennis Boschetto. I'm the administrator of a 235-bed Extendicare/Falconbridge facility here in Sudbury. I'm also the Ontario Nursing Home Association, region 1, representative on the local district health council long-term care committee.

Mrs Nancy Foreman: I'm Nancy Foreman, the director of care at that same nursing home.

The Chair: Just for our information, region 1 comprises—

Mr Boschetto: Region 1 comprises the area of Sault Ste Marie, Sudbury, North Bay, Cochrane, Timmins, Hurst, Kapuskasing and so forth; the far north also.

What we're going to do is that Nancy Foreman is going to read the presentation from the Algonquin Nursing Home. I will interject with overriding comments from the Ontario Nursing Home Association and from Extendicare itself to clarify points and to make recommendations, and then we'll both be available for questions. Unfortunately, the items that Nancy is presenting are directly from Vala's presentation and we wouldn't be able to answer any questions as to what her comments were.

The Chair: Thank you very much both for the explanation and for coming, and now please go ahead.

Mrs Foreman: On behalf of the 72 residents of the Algonquin Nursing Home, the 65 staff who care for these residents, and the management of this facility, I am here to present some of our concerns about parts of Bill 101.

On the whole, we are pleased that the Ontario government is moving ahead with the reforms to the long-term care system. For too many years, nursing homes have been regulated differently from other long-term care facilities.

Bill 101 attempts in many ways to develop the same set of rules and regulations for nursing homes and homes for the aged. Bill 101 indirectly acknowledges nursing homes to be a necessary and vital part of Ontario's long-term care system. Many of the regulations put forth have been standard practice in nursing homes and will now only start to be met by other long-term care services.

Algonquin Nursing Home is part of the Ontario Nursing Home Association. Algonquin has been accredited for over ten years by the Canadian Council on Health Facilities Accreditation. Our residents, their families, the community and the staff are a team that have made this nursing home a home, first, where nursing care is provided.

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Throughout the following pages, please remember that it is for these residents and their families that the recommendations have been made. Many of the suggestions have been made by the staff caring for the residents and by the families involved in looking after the residents' personal affairs. Many staff who look after the residents know at first hand what is necessary and workable. Often, philosophy looks great on paper, but the human aspect must be applied for philosophy to be practical.

The service agreement, which has not been made available for evaluation, must be reviewed by this committee and by the people providing the care, to ensure that the agreement is workable and understandable by the public, and possible to fulfil equitably by government and service providers.

Mr Boschetto: On this issue, the Ontario Nursing Home Association would like to address the issue of moving from the insurance model under OHIP to a contractual model with the nursing homes. They go on to state there is a very serious public policy ramification with Bill 101's move to put long-term care facilities into a contractual agreement model. This means that there will no longer be a universal, accessible approach to health care in these facilities, since the extended care program will no longer be an insured service under OHIP in Ontario.

This bill avoids any government responsibility to fund these homes equally in order to provide the same level of service to everyone across the province. The government could treat many of the facilities differently, and has, through this legislation, provided the vehicle to fund some programs in some facilities while not doing the same in others.

In the area of capital and other funding, such as pay equity, it enables the government to continue to discriminate against private, for-profit sector homes. Already, non-profit long-term care facilities have received pay equity funding, while staff in private sector nursing homes have been told that government, at present, decided not to pay for pay equity in their homes.

Each year, the service agreements must be renewed and government will have no obligation under this act to fund the level of care required by residents or to continue to fund programs if it chooses to change the agreement.

There is no arbitration or appeal mechanism in the service agreement, so homes will simply be subject to the

government's whim regarding policy and programming, regardless of its ability to fund these services adequately or if it funds them at all.

It is recommended that the government must be held accountable to maintain equitable and consistent services in all long-term care facilities throughout Ontario, regardless of whether they be for-profit or non-profit.

The Chair: Could I just make it clear, because of Hansard, people later on reading the testimony, that when you're speaking, that's region 1. Otherwise, it's the people from Algonquin.

Mr Boschetto: Yes.

The Chair: Fine. Thank you.

Mrs Foreman: Bill 101 sets out a new placement function called "placement coordinator." The details of how the placement coordinator will function must be specified. Consumer choice is not given priority, and an applicant's ability to appeal a placement coordinator's decision is limited. Further, facilities are not given an opportunity to match potential residents' needs with the facility's mission, services and programs. Placement coordinating agencies should be managed at arms length from service providers, or there must be equal representation on PCA board by all service providers.

Algonquin Nursing Home is located in the small northeastern Ontario town of Mattawa, population 5,000. Our nearest city is North Bay, 40 miles away. The communities are different in language, economics etc. Placement coordination services need to be located in all communities. They need to be open 24 hours a day, seven days a week and be available to all citizens for all types of care.

Both the potential residents and the long-term care facility must be given the ability to refuse admission for reasons such as the potential resident or the potential facility do not suit each other, for example, smoking residents and non-smoking facilities; shouting residents in a small nursing home where the residents must share one lounge; age differences, a young resident in facility with a vastly older age group, and so on.

If a facility has empty beds and is aware of another area in the province in which there is a waiting list of people willing to relocate, the placement coordinator must seek these potential residents to fill the beds. Empty beds directly result in decreasing a portion of the revenue that pooled together, provides certain resources that the entire resident population shares, and therefore, empty beds indirectly affect resident care.

Placement coordinators must be required to identify a substitute decision-maker for the applicant and a responsible party in the event that there is a default on the financial obligations of the resident, and to establish the applicant's ability to pay the copayment. Bill 101 states no explicit authority to collect payments from residents, nor obligation for the resident to pay. Unpaid bills directly affect the ability of the care giver to provide the necessary care to all the residents in a facility.

Placement coordinators must also be responsible for the discharge planning and coordination involved when residents of long-term care facilities need to be moved to other locations

Mr Boschetto: ONHA, in looking at placement coordination, has three specific recommendations that it would like to make in addition to these comments.

- (1) We recommend that the existing resources be used for placement coordination function and that no new level of bureaucracy be created for this purpose.
- (2) Applicants must have an appeal mechanism with respect to placement, and this appeal mechanism be accessible in a timely and efficient manner. In a previous presentation, it was suggested 30 days and I believe that would be too long, that for people who are under this type of stress and who need placement in a facility, 30 days can seem like a very, very long time.
- (3) Facilities must have an appeal mechanism to challenge placement coordination recommendations when the facility believes that it cannot meet the care needs of the applicants properly and safely. This appeal mechanism must be accessible in a timely and efficient manner, and we believe, because of the dangers that can occur from admitting residents to nursing homes where the admission is not appropriate, that this must also be much quicker than 30 days.

Mrs Foreman: On behalf of the residents of a facility and its staff, many of the suggested sanctions for facilities in breach of their service agreement are immoral. In many cases, the sanctions such as freezing admission or with-holding payments will in fact jeopardize the provision of care to existing residents in the facility. There must be an efficient appeal process. Surely, with proper inspections and the proper application of regulations and the normal follow-up of inspections, there should be no reason for any harsh measures to be implemented. Any measures taken must not affect the ability to provide resident care.

Mr Boschetto: ONHA, when looking at sanctions, says that the sanctions should only be implemented as a final resort, and that facilities must have a right to appeal sanctions implemented. We would prefer that appeal could occur before the sanction is implemented.

Mrs Foreman: The bill also sets up a more adversarial approach to inspections than under the current Nursing Homes Act, an approach which the government's own study had already proven to be a poor method of monitoring facility care and services.

In the 1970s and early 1980s, nursing homes were policed by the nursing homes branch. This system was non-productive, did not result in improved resident care and created ugly confrontational relationships which suggested the government was incompetent in managing health care.

In the late 1980s, the system was changed to include compliance officers. I can assure you that this harmonious working relationship is the best for the residents of long-term care facilities. It encourages the ongoing improvement of resident care and services. It continuously fosters increased staff knowledge and management efficiency. It has resulted in trust by the residents, their families and the public.

The bill leaves too many issues to regulations. It provides too much power for the government and its inspectors without requiring a corresponding measure of accountability. The bill holds facilities accountable for providing for all residents' needs, without ensuring that funding will be provided to make this possible.

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Mr Boschetto: The ONHA would like to bring the government's attention to the Woods Gordon report of 1986, commissioned by the government, which examined the effects of the enforcement approach versus the consultative approach. It stated that the adversarial climate between inspection branch and nursing home was detrimental to solving problems, that the Ministry of Health, with its scarce resources, was unable to focus its efforts on issues of greater importance to the residents' health and safety. In fact, the Ministry of Health has an existing compliance management program that has proven to be very effective in monitoring resident care and programs.

The amendments that cover the area of inspection are clearly designed for a worst case scenario, putting in place very broad powers that would result in inconsistent and potentially unfair application of the sanctions and inspection process. The legislation sets up a very adversarial approach between government and facility. This adversarial approach, together with the contractual model of service, may result in increased litigation and civil action between government and long-term care facilities, and an unnecessary waste of scarce resources.

ONHA continues to support accountability for all aspects of care to government and the public on the part of long-term care facilities, and recommends that the powers of inspectors not be increased and that the existing compliance management program be continued.

Mrs Foreman: The requirement for a care plan that is set out in Bill 101 is specific. Neglectfully, the government's commitment for funding to ensure that the care plan be carried out is not specified or even mentioned in Bill 101. This renders the intent of the requirement for a care plan immaterial. This will make the legislation ineffective, the end result not progressive and still continue the discrimination against residents of long-term care facilities. As a result of this oversight, care plans will not truly reflect the needs of a resident as there will not always be the necessary funds to ensure proper care.

Mr Boschetto: ONHA would like to bring its concerns regarding resident care needs and meeting those needs to the committee. The bill is being introduced in a vacuum. There is no requirement that funding be established and maintained at the level required to provide adequate services and programs to meet the care needs of residents. There is no information on the service agreement and too much is left to regulation.

The bill requires each home to have a service agreement between it and the government, a plan of care for each resident and a written notice for each resident describing what services are being provided under the service agreement by the operator of the facility. The service agreement has not been made available to long-term care facilities or this committee for their review.

There is no accountability for government to provide the funds to meet the needs of the service agreement. The service agreement could change annually depending on the funding available for that year. The proposed classification system will only be used to allocate available funds for nursing and personal care. Quality of life programs and accommodation will be funded under another, to date unknown approach.

The resident classification process does not measure actual resident care requirements. It only enables the government to develop a case mix index, a way of scoring each facility's care level relative to another. Only the case mix index is established. Government will simply use it as a formula for distributing funds between facilities. This approach will not guarantee that funding will be sufficient to ensure the assessed needs of residents. It merely is a process by which the government distributes limited available funds to each facility.

The requirement for a care plan is set out in the legislation. As well, the legislation requires that the care outlined in the plan must be provided. There does not appear to be any flexibility should the resources not be available to provide the services outlined in the care plan. In fact, the legislation may discourage accurate and detailed care plans due to lack of resources. Because there is not enough money in the system to meet all the needs of assessed residents as identified in their care plans, facilities will automatically be in breach of the contract.

The ONHA is concerned that the legislation focuses on paper processes and not the outcomes of care. Delivering care to residents is more important than filling out paperwork, and an over-emphasis on paperwork reduces the amount of time available for care.

Further, the bill provides an immunity clause for acts done in good faith by placement coordinator and inspector, but does not for facility staff. Facility staff require the same protection.

ONHA recommends that the legislation should not require facilities to provide all services as defined in the care plan unless the government assumes responsibility for funding these services. If, as we believe, funds are not available, then priority setting and flexibility in interpretation must be provided for.

Mrs Foreman: Long-term care services in small communities must share resources. Home support agencies with wheelchair accessible vans must share their transportation with the residents of nursing homes and homes for the aged that do not have such transportation.

In the area of capital and other funding like pay equity, Bill 101 allows for discrimination to the residents who live in nursing homes by not providing the same funding that not-for-profit homes already receive and will continue to receive. This does not make for an equal, just or honest system.

Mr Boschetto: Around the issue of quality assurance, ONHA would like to make its viewpoint known that Bill 101 requires each home to develop a quality assurance program. This is a very restrictive term which describes one particular management process. Management systems

are constantly evolving and changing. The more prevalent management system in use today is total quality management and continuous quality improvement.

ONHA recommends that rather than specifying a specific management system, the use of a generic term such as quality management be implemented. ONHA would expect that the quality assurance management records will be treated in the same way as set out in the Advocacy Act. These records are for the facility's use to improve its services and not for use by inspectors to criticize a facility's delivery of care.

ONHA recommends that inspectors should not be entitled to have access to personnel records or to the record or part of a record dealing with quality review activities, peer review or performance review activities, or quality improvement activities within the homes.

Mrs Foreman: Thank you for having given me the opportunity to present this paper. I urge you to pay heed to its recommendations. The staff of this home and most other homes provide good, loving, effective and efficient care. We know what type of care is necessary, available and supportable.

The people of Ontario deserve a good, long-term care system, they deserve good care. The families of the residents need to trust that their relative is receiving the best care available in the province, and that care giver facilities and the government have worked together fairly and cooperatively to ensure that the long-term care services do not discriminate against people.

You have the ability at this time to determine Ontario's future fairly. Please do not do disservice to the people.

Mr Boschetto: On behalf of ONHA and Extendicare Health Services Inc, I'd like to thank the committee for allowing myself and Nancy Foreman to be here to present to you today, and I hope we haven't confused things too much by combining the two presentations.

The Chair: Not at all, and we thank you for taking the time to put the two together in a way that was informative and helpful. If we might, back through you, I want to make sure I get it, was it Vala Belter?

Mrs Foreman: Yes.

The Chair: Perhaps you would convey to her our best regards for a speedy recovery. We'll move then to questions, and Mrs O'Neill.

Mrs O'Neill: I guess it's two briefs, but it's certainly a very strong statement. You've given what I consider are some very practical points for the committee to work upon. I'm very happy that you have used the term "worst case scenario" and that the inspection in this bill seems to build on that, because that's our opinion on this side of the table.

I'm glad you talked about the nursing home inspections because I don't think we should forget that. It hasn't come up very often in the hearings what an unsatisfactory system that was. We have had a couple of presenters talk to us about the happy relationship they've had with the compliance officers in their regions and I'm glad you reiterated that. The vacuum regarding funding is also something that concerns us greatly, and it must concern you greatly because you're the ones who have to administer in the field.

You said that the care plan is a problem. You didn't say very much about that. As a result of Bill 101, it will definitely, I think, be on, what should I say, thinner ice. Do you want to say a little bit more to us from your own experience, or from the brief you presented, about the care plan problem of Bill 101?

Mr Boschetto: The one issue with the care plan is not the development of the care plan, because our facilities all have care plans in place and we believe the care plans are good. The problem around care planning comes that if you identify issues within the care plan that must be dealt with and you do not have the available resources to deal with those issues, you then, under this new legislation, are in breach of your contract and then subject to sanctions.

What we would like to see is a system where there is some flexibility and some allowance for not being able to meet the needs of the care plan.

I might give you one small example that may occur, and that is that in the 26 Extendicare nursing homes in Ontario, there are only two that have a social worker in place. There are many issues that could be dealt with for family members and residents that require a social worker in the nursing home. If those facilities are not contracted to provide social work services and the government does not pay for social work services, how do you then go about meeting the needs of the resident that are social work intervention requirements?

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Mrs O'Neill: Do you see it tied in at all with capital?

Mr Boschetto: With capital funding of the nursing homes? The issue of capital funding has been a big one between the for-profit nursing homes sector and the government. There was out west up until recently, in Saskatchewan and, I believe, Alberta, a formula where the government provided 75% of funding for capital over a 25-year amortization basis, which is something we would like to see here in Ontario. What you have to realize is that facilities today are taking care of residents who are at a significantly higher level of care than when the institutions were built some 20 years ago—and many of them were built at that time—and there may be issues around the capital costs of renovating facilities.

You are probably aware at this point that the compliance plan for structural compliance is due in June 1993, I believe, and there are many facilities in Ontario that are not structurally compliant. I guess the question would be to the ministry: Is it planning on closing these facilities down after June 1993, or is it willing to provide some funding to assist these facilities in meeting structural compliance?

Mrs Marland: Even doing your presentation as a joint presentation as you did, which I'm sure wasn't too easy for you, you ended up with a very powerful presentation and you made some very powerful statements as a result. I hope the government members are listening, and if not, I hope that perhaps the government staff will be able to convey your very serious concerns back to the minister. I don't expect the minister to wade through Hansard and extract some of the comments that are being made, as I've heard from you, very constructively. I think it's obvious

that the district health council is very lucky to have you serving on that board.

You touched on the inequities that exist today, the fact of the pay equity funding going to the non-profit staff. I have never asked any of the presenters to this legislation something directly about that as an example of what this government has been doing, because obviously they've been doing the same thing in providing pay equity adjustments to the non-profit day care centres as well. But from your experience—either or both of you—do you find that this kind of decision made by the current government has a very adverse effect on the morale of your staff?

Mr Boschetto: Just a couple of issues: First of all, I would like to make it very clear that the Ontario Nursing Home Association, Extendicare Health Services and the Algonquin Nursing Home in Mattawa, and all others that are members of the association, are looking at Bill 101 not as in trying to tackle the government on any issues, but rather that we support the implementation of Bill 101 with teatin amendments, and the suggestions we've brought to the table today, in order to make Bill 101 a fairer bill and an equitable bill for everybody that is involved.

Around the issue of government funding of items such as pay equity and capital, once again—because that is another issue around monetary and how it affects staff morale—we and all of the groups I previously mentioned have worked with every government that has been in place since the mid-1960s, when I believe legislation first began to increase in power. We have worked with the PC Party, the Liberal Party and now the NDP that is in power.

What we have found is that because of delays on promises by all governments through history, it does affect morale within the facility, most recently being the delay of the implementation of levels-of-care funding. We increased staffing levels in 1992 in anticipation of January 1 funding of levels-of-care funding, and as you know, the levels-of-care funding has been postponed. We believe that it is supposed to be some time in 1993, but we do have serious doubts as to whether it might be before January 1, 1994.

When it comes to the morale of our facility, we went in last year in the spring, increased staff in our particular facility, as many others did, and the staff are very happy. Because the level of care has been increasing over the years, we do see the need for more staff in the facilities, and we do see the staff happier and more relaxed when they are able to provide the care they feel they should be able to provide, and also having those few moments to sit with residents and talk; not just doing their work.

As a result of the delay of the implementation of levels-of-care funding, there are some nursing homes in Ontario that will now be cutting staff back to December 19, 1991, levels. That, for those facilities, will be a very detrimental action towards staff morale, and it is a direct result of levels-of-care funding not being implemented on time.

You may take that and you may also apply that to other issues. Our staff look at other facilities and say: "Why are they able to do it and why can we not? Why does Pioneer Manor have a bowling alley in its facility and why do we not?" That's the simplicity of what you need to look at in facilities.

Mrs Marland: I like your recommendation about using existing resources and not setting up new bureaucracies. I thought that made a lot of sense.

When you were talking about how there must be an appeal mechanism for the placement decisions, you went on to emphasize that the appeal mechanism must be available for both sides, both the client and the facility. Have you any suggestions about how an appeal mechanism could be established that would work, to use your own words, without waiting 30 days to have somebody hear an appeal and make a decision?

Mr Boschetto: It could be done through the local communities and possibly through existing organizations, where two organizations that differ in their opinions such as placement coordination service and a facility such as ours would have a predesignated single arbiter, and that arbiter would be available to look at specific cases on an as-need basis; not that there would be a new position created within a community.

I think it can be a very simple process. I think that what happens within legislation such as this and within the operation of nursing homes and governments is that we tend to make things more complicated than they really need to be. A family member who is disagreeing with a placement decision or an eligibility decision who has to wait any more than a few days is going to be very stressed out. They are already stressed because they are looking at placement. They possibly have some internal conflicts about what they are doing with their family member and what their responsibilities are as sons or daughters or mothers or husbands or wives. Making them wait up to 30 days or possibly longer for an appeal process is unfair. We believe on the facility level it is also unfair and that it should be as quick as possible. I don't see any reason why, with a single arbiter in place, it couldn't be done within a day or two.

Mrs Marland: A single one from each side? You mean two arbiters?

Mr Boschetto: No, the same way that it works in labour relations, and that is, if you have a union and an employer who disagree, the two of them get together and agree on one arbiter, somebody whom they trust to make a decision. The person would hear arguments on both sides of the cases and make a decision. After all, the decisions will not be complex in nature. A review of documentation, medical assessments and the assessment tool would indicate very quickly, I think, what needs to be done.

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Mrs Marland: I think it's interesting, Mr Boschetto, that you also referred to—I don't know whether it was in your brief now or the one that Nancy Foreman presented on behalf of the Algonquin Nursing Home, but one of you said that too much was left to regulation, and that is something we've been stressing our concern about, from the beginning of this bill, in our PC caucus. We're asking all the time to see, if possible, what some of the regulations at least might be, but of course we're not making any headway with the government on that score. That relates to

another statement one of you made about the vacuum re

The whole thing is that none of this will work. It will all be pie in the sky and totally impractical if the funding problem isn't resolved. I'm not terribly optimistic, with a \$12-billion to \$13-billion deficit, that new money is going to be coming from anywhere very quickly. We've already heard that some of it, we feel, is going on the backs of the seniors themselves. We heard that from one of our earlier presenters here today, about the concern about the copayments and where seniors were going to have to be finding more money to support that particular form of care for their family members. There isn't an easy solution, so as great as some parts of this bill might sound in theory, I do share your concern about the vacuum re the funding issue.

Mr Bisson: Just two quick questions, not a long preamble: On the question of the appeals process, an interesting comment, would you suggest that if you went to a system like that, you would have to go through a formal process of reappointing the arbiter every year or so?

Mr Boschetto: I think that's something that could be discussed between the placement coordinating services and those people they service. I could only speak for Sudbury and area and how it might work here.

Mr Bisson: Just to be direct with the question, let's say that was put into the regs. As a concept, it's not a bad idea. But it was written in that every year or two or something like that, both parties would have to get together and agree or disagree on a new arbiter. You know how arbitration goes. Maybe you'll get all the decisions and the other side's not happy and vice versa. Would that be acceptable?

Mr Boschetto: I think that would be something we could look at.

Mr Bisson: The other thing I want to come back to is that you're affected, I think, similarly to one of the other presenters prior to that in regard to the whole question about, not so much levels-of-care funding, but the question around—the Extendicare units pay municipal taxes, right?

Mr Boschetto: Yes, we do.

Mr Bisson: Okay, we're not going to get into a whole bailiwick on this one, but you're also faced with the same problem in regard to, if somebody doesn't pay, what do I do? What is your suggestion on that? It's not as easy to solve as saying the government put it into regulations, because we'd almost have to get into the collection business or something to be able to deal with it. Have you given it any kind of thought?

Mr Boschetto: I'll speak from an Extendicare perspective, from Extendicare nursing home services. We have a very intense system for aging of accounts payable. We have had in the past severe problems with attempting to collect payments for residents staying in the nursing home. As you're aware, the regulations state that if I want to move somebody out of the nursing home, I must find another place for him or her to stay. That's not a possibility in most cases, so that you have to deal with the person who is in the nursing home. That's why we have developed contracts that are signed between the nursing home and the

resident or the resident's family, responsible party, whoever's taking care of the finances. We do not hesitate to enforce those contracts

As opposed to the other person who presented here who says they're somewhat uncomfortable approaching families, we believe that there's a contract established there between a person who is requiring services and ourselves who are providing the services, and therefore we require payment in order to provide those services.

Mr Bisson: Any seizure around assets and things like that?

Mr Boschetto: No, we do not go into assets. Unlike the municipal homes, we don't deal with residents' assets at all. However, we have in the past filed, in either Small Claims Court or provincial court, an order to obtain payment. I can tell you that at this time in Sudbury, we do have some very significant collections problems. People who learn the system do find ways around it.

There must be something in the future to help us collect bills or to move people out of facilities who do not want to pay, because we know the Ontario government guarantees that every person over the age of 65 can afford a ward accommodation in a nursing home. We know they are receiving at least that amount of money, plus \$112, and there's no reason for not paying for the accommodation. If a person doesn't pay the accommodation, his or her stay at the nursing home could be terminated. After all, if you are being provided money to buy goods, and you buy the goods but don't pay for them, what should happen?

The Chair: I'm going to turn to Mr Wessenger, and just note to committee members that the next presenter, the Medical Society of Sudbury, is on its way, but is not here yet. After Mr Wessenger completes his questions, in the event they're not here, I would be prepared to allow one or two more questions, if you will allow the Chair a little flexibility until the society representatives are here.

Mr Wessenger: Thank you for your presentation. One thing I'd just like to clarify: This question about the 30 days, it's the client who has 30 days in which to make an appeal. That doesn't really apply to the question when the appeal will be heard. It's 30 days after the decision, but I'd like to sort of pick up on that point with respect to the situation concerning a dispute between the placement coordinating agency and the facility with respect to the admission of a client. I'd like to ask, does that happen very much now at present under your placement coordination system?

Mrs Foreman: I would say, rarely. Our placement coordination service in this area is relatively new and is working out very well. It's a pick up the telephone association; it's not a formal—they're as close as the telephone.

Mr Boschetto: I'm sorry. If I could just add, the one difficulty that has arisen that we have three documented cases on over the past six months is that when somebody is admitted to the nursing home, and is admitted beyond our level of care because of a situation that has arisen in the meantime while he has been on the waiting list, we see that this situation could be corrected with the efficient use of a placement coordinator where the assessment is done,

prior to the admission, so that we would avoid those types of cases. However, there are two issues that come about as a result of doing that.

First of all, if you do obtain an admission that's inappropriate, how quickly can a placement coordinator move them out of the facility so that you don't jeopardize the safety of the residents who are there, or the resident himself. Second of all, if a placement coordinator has the power to admit or discharge from a facility because of those types of problems, how does the nursing home get paid, if as a result of its decision, we would lose resident days in payment for those resident days? For example, if a bed remains empty for a day, two days or three days, right now there's no provision by the government for paying us to maintain a bed vacant while we're waiting for an appropriate admission, so we would have to deal with that situation.

Mr Wessenger: Before I continue my question, just in respect to your question, I think I'll let ministry staff respond to that specific—

Mr Quirt: Under the current health insurance approach that you mentioned earlier, you're quite right. There's an issue with funding flowing to a nursing home if no client receives service. One of the advantages of moving away from a health insurance approach is that we can, for the first time, have a direct relationship with the nursing home funding-wise. Currently, we don't fund nursing homes directly; we have to insure the clients who live there.

With a direct contractual model, we can set an occupancy expectation for each facility, and depending on the demand for respite care services in your community, accommodation expectation would be set in accordance with the extent to which you were called upon to deliver respite services. So in effect, we can fund you to keep beds open for respite purposes and also fund you appropriately so that you're not under undue pressure to admit someone when a vacancy occurs.

Mr Boschetto: Just in response to that, one of the things the Ontario Nursing Home Association has been a strong advocate of is the facility's plan for the future, that we be able to count on resources not only from month to month or year to year, but for years in the future. Changes in legislation and the activities of government over the past 15 to 20 years have left us in a situation where we are for-profit operators who were encouraged to open beds and to operate in the province, and now are being put in a situation financially where we are literally going from month to month and year to year, and as you know, some of our operators have not been able to make it that far.

When you talk about going to a contractual model and providing direct funding and being able to work with the nursing homes, I take that as a positive and an encouragement that in the future the government is looking at allowing for-profit facilities that are able to operate more efficiently—I think that has been proven to government—to be allowed to operate in this province and that we are allowed to make a reasonable level of profit for providing services from those accommodation fees that are paid.

We are not interested, as you know, in making profit on the personal care or the program services, but we are interested in continuing to be a healthy organization and a health care provider in the Ontario system.

1440

Mr Wessenger: If I just might follow up on my questioning concerning the situation of the disagreement between the placement coordinating agency and the facility, it would seem to me that going directly to an appeal process is perhaps not the most satisfactory in the sense that it would be better to go to some sort of dispute resolution model at the local level, which would involve negotiation and mediation. Would you agree with that?

Mr Boschetto: I would always agree with mediation before going to an arbiter. I would say, though, that this process has to be simplified. I believe that it could be simplified to the extent of whoever has the objection makes a phone call and has access to somebody who can make a decision who both parties have agreed to talk to.

We all know that this type of mediation system is in place in labour relations and that it can take anywhere from a few months to a year and a half to get to a decision. That is the type of situation that we don't want to have to have happen within the nursing home sector and within communities.

I do firmly believe that within a city like Sudbury, or the Sudbury-Manitoulin district, there should be access to somebody who would be able to go in, look at the documentation and make a decision with very little effort on everybody's part.

You're dealing with, in our case, a facility that has a lot of experience in nursing home services and the acts with the ministry and dealing with government services. On the other side, you have family members who are totally new to the situation. They need something that is very quick and very fair and they need answers in that manner.

I agree with mediation. However, in this case, I believe we can shorten that process and do it all under one.

Mr Wessenger: I have just one other question with respect to the whole question. I think it has been made quite clear at other hearings that certainly the compliance model that now exists is intended to be continued under—and in fact it's interesting that our present legislation on the Nursing Homes Act and as it continues on the new legislation has the same sort of statutory model. Are you concerned that there might be a change in policy from the compliance approach? Is that really your concern?

Mrs Foreman: This is the feeling we have been given, that we're going back to a police-type approach, in making sure that the regulations are in place. I've worked under both, both the inspection process and the compliance process. My experience with the compliance process is that whatever areas of deficiencies they may find, they have a wealth of information that they can share with us. These people go from home to home to home and collect a lot of good ideas and a lot of problem-solving skills, and they would share that with us and are in fact doing that now. Under the inspection process, they would find us in violation for whatever and that was the end of it and then we had to do all sorts of digging and trying to find out how to correct it.

I like the compliance process and I welcome any external audit. I want that process to stay in place, but with a professional approach to it.

Mr Wessenger: The only thing I can do is that I can assure you that certainly the compliance model, as it presently is working, is intended to be continued. I don't know whether I can say anything more than that. The last item is the whole question of the—

Mr Boschetto: If I could just add one item to that, with the inspectors, the power of inspectors is also a question, and of real concern are quality management or quality improvement documents within the home and our records as they relate to personnel records.

That is something we feel must be protected under this legislation, and that the inspectors not have access to that information, because it has been known in the past that this information can be used against us in a court. We would want that information protected, because either we need the information protected or it can't be there, but it can't be both.

Mr Wessenger: Just one final comment: I noticed you had some concerns about saying lack of consultation with respect to the service agreement. I was curious about that, because the information provided to me is that the Ontario Nursing Home Association was a working group participant with the service manual. The draft service manual was circulated in October and in fact we have received actual comments with respect to the service agreement from your association.

Mr Boschetto: We haven't received copies of the service agreement within the facilities locally.

Mr Wessenger: Oh, the specific facility, you're talking about.

Mr Boschetto: Yes, the specific facility. We haven't received them. It's just as with notification of this meeting; we found out about this meeting by accident on Friday morning. In the past the ministry has sent us a fax, has called us, has followed up with documentation by mail. If it wasn't for the fact that I was listening to the radio on Friday morning, I have received no documentation in my office about the existence of this meeting today. I don't know how other people received notice of it, but we did not and neither did our sister facility.

We are looking specifically at the contractual-type agreements and what is going to be required from the nursing homes, the service agreements. We understand there was a presentation to be made on March 5 here in Sudbury on the new manual. However, that same presentation will not be made to the Ontario Nursing Home Association until later on in March, so the time frames don't seem—they were quite surprised when we told them we were going on March 5, noy to the consultation but the information sessions, when theirs has been postponed to later on in March. I don't know if communications have faltered a little bit in this area.

Mr Wessenger: Thank you very much.

The Chair: In terms of communications, I continue to be amazed at how, supposedly, we have tremendous communications in the world these days, and yet people aren't aware of things they should have been, and for that I apologize. I said this before, but I don't know whether you were here: There was quite an extensive process at least that we tried to put in place in the committee.

I'm just curious, but would not the provincial nursing home association have let all of you know that this was going on as well? I'm not saying that they're the ones responsible, but I'm just wondering about, perhaps, internal communications as well.

Mr Boschetto: Their mailing did go out last week and we had to request faxed copies in order to prepare for this meeting today, so I think there may have been some confusion around dates.

The Chair: A memorandum was sent in December to all the major province-wide associations, informing them that these would be taking place, and I'm just concerned. There have been enough comments that when I get back, and we have completed our hearings, I think we need to look at how we inform people, because inevitably, whether it's an ad in the paper or letters to different associations, it just seems that some people who you would think would be aware aren't, and that's not good enough.

1450

Mr Boschetto: We do not feel that there was any attempt to exclude us from the proceedings. However, we receive a multitude of documentation letters from the Ministry of Health, and we found it strange that this wasn't forthcoming also. There's never any hesitation from the Ministry of Health or local MPPs to come into a nursing home when there's a problem or a complaint.

Mr Bisson: I've gone to visit you three times. I want to put it on the record that I have gone to visit you three times. I'm not even a local member, and I've gone three times to see you.

Mr Boschetto: That's because you're a friend, Gilles.

The Chair: One of the reasons perhaps is that this is a standing committee. This is not a function of the ministry, so it wouldn't necessarily be communicating about it. I think it does go back to just looking perhaps at how, as standing committees, not simply this one but others, where there are a large number of groups and organizations, how we make contact because for those who are deeply involved in it, they're aware, but I just wanted you to know we take that issue as an important one and want to try to improve on it.

If I could just say to the committee, the next group, the Medical Society of Sudbury, is to be here in a few minutes. They aren't here. The Chair is prepared to entertain a question or two, if there is a question or two. I don't mean to keep you at the table, but Mr Bisson is going to tell us about his travels through Ontario.

Mr Bisson: Just two things: One is with regard to the presenter and the other one is around the next presentation. So members understand the story, we go back to days before I was a provincial member and we had this exact discussion about government members should be travelling around talking to people in institutions, and after being

elected, I followed up on that three times and unfortunately you weren't there. So don't say we don't, because we do.

The other thing is on the other presenters with regard to the association. Normally we're not in the process of waiting around. I just find this a little bit bizaare because I've been in a lot of committee hearings. If they're here, they're here; if they're not, they're not. We're prepared to wait a couple of minutes, but at one point we have to put that—

The Chair: They're scheduled for 3 o'clock and it's not 3 o'clock, in fairness—

Mr Bisson: Okay, because I didn't have him on my schedule; that's why I was wondering.

The Chair: Right.

Mr Bisson: Okay, as long as we have a time on this.

Mrs O'Neill: Am I to understand that St Joseph's General Hospital now will not be able to present? Is that correct?

The Chair: They phoned and said they would not be here.

Mrs O'Neill: I'd like to say a couple of things, if I may, and I'd like to ask one more question, if I may.

The Chair: You may, in each case.

Mrs O'Neill: I really do think we have to examine our communications with the north. Even on the plane coming up yesterday, a member of OPSEU, who is a member of the long-term committee of OPSEU, did not know about these hearings, even though she's a resident in the city of Sudbury and has a special interest. There is an extra need of people who are in the field and who are not being somehow informed that we're coming, because we don't come, in my humble opinion, often enough. It's very easy to get very tied to Toronto and I understand the concerns, maybe not the same extent, being from eastern Ontario.

In any case, I think you've all stated that very clearly today and we will have to, as a committee, examine that, and I think our Chair will be very cooperative in our doing that. You said the case mix index is also of very grave concern to you because of the way the funds will be so dependent. Can you say a little bit more about that, just for our own understanding from the practical point of view?

Mr Boschetto: The case mix index, when you look at the levels-of-care funding, what is happening is that the residents are being assessed and from the assessments that were received, they developed the case mix index which will tell the ministry how to divide up the available funds, so that if the case mix index is based on one, that person will receive one percentage of the total amount of funds available for the province.

The problem with the case mix index is that it does not fund according to the level of care required by the resident, but simply as a percentage of the total funds available. Therefore, if a case mix index is developed and the medium is determined to be 2.25 hours of care per day, then that is how the funds will be distributed among the system, even though you may have all your residents in your facility who actually require more than 2.25 hours of care. You see, there isn't a direct funding of levels of care.

Mrs O'Neill: Are you also worried about—others have brought to our attention the kind of snapshot picture on the day on which that's determined.

Mr Boschetto: That is not a grave concern unless the level of care that is within your facility is increased significantly over a year. We understand that the assessments will be done on a yearly basis and hope that to be true. But the snapshot would come into effect if, over the period of that year, they decided to reduce the number of chronic care beds within the community and that we would be receiving a significantly higher level of care within the facility, or if we were discharging residents who were at the F and G level in the matrix, and were not allowed to admit the same level but were required to admit a higher level of care, as in chronic, or if we were discharging people at the A and B level and were required to admit people at the D, E, F and G level. That would be a significant concern to us.

The Chair: I believe ministry staff have a clarification they wish to make on one of your points, which might be of help.

Mr Quirt: I just wanted to clarify the case mix index and how it's used. The ministry has been very clear to date that the Alberta resident classification system, modified for use in Ontario, is a tool that allows us to fairly distribute the resources the province makes available for nursing and personal care in long-term care facilities.

In reference to 2.25 hours earlier, under the current funding arrangement, which provides approximately \$78 a day in insurance coverage to each nursing home for each day of service provided to a resident, there is a requirement that nursing home staff, at 2.25 hours, in order to be eligible for some additional enhancement funding—but under the new levels of care funding formula, there will be a requirement that the nursing home spend the amount of money provided for nursing and personal care, and that amount of money will vary in accordance with the measurement of nursing and personal care requirements in the facility.

It is not an attempt to define precisely the right amount of nursing and personal care that should be provided to each resident in each facility. The amount of money made available by the province for funding long-term care facilities will continue to be a provincial decision, a decision taken by the government and ultimately by the Legislature.

If one were to look across the country, you would find 10 different "right amounts" to be spent on care in nursing home and homes for the aged. The purpose of the Alberta resident classification system is to distribute as fairly as possible the funding that the province makes available for long-term care facilities, and through the redirection, there will be \$206 million more spent on care in long-term care facilities in Ontario.

Mr Boschetto: I have a question, if I might. From the assessments that were done in September and October, is it not possible for the government to determine what the actual care requirements are in the nursing homes, and instead of taking a pool of money and dividing it among 59,000 residents, go in and supply funds to provide the level of care that's actually required?

Mr Quirt: The Alberta resident classification system does not tell us that a particular resident requires a definitive amount of nursing and personal care. As you're well aware, a similar client in Ontario, in a nursing home or in a home for the aged or in a chronic hospital, all with identical care requirements have, by a factor of three, a tremendous different amount of programs and services delivered to them

In your facility, your client would have \$78. The facility would have \$78 to spend on that person. The identical client in the average municipal home for the aged would have \$120 spent. There are those who would argue that the identical client in a chronic hospital might have \$225 spent. Somewhere in that range you would have an opinion on what the right amount is. Others would have varying other opinions on what the right amount is.

The redirection initiative allows us to distribute the funds the province makes available for care in nursing homes and homes for the aged in as fair a way as we can find to do that. In addition to the existing level of funding for nursing homes and homes for the aged, an increase of \$206 million will be added to the budget as an equalization fund, to bring much closer the relative amount of support provided by the province for residents in the three categories of facilities that the bill deals with.

Mr Boschetto: Could you tell me when that's going to be implemented?

Mr Quirt: Yes. It will be implemented with the pleasure of the Legislature: if it passes Bill 101, as quickly as possible after that.

1500

The Chair: Thank you. You've been very patient and not only answered our questions, but I think have provided information as well on your own operations which has been helpful to the committee. We want to thank you for coming and making your presentation as well as that of the Algonquin Nursing Home. Thank you again for being here today.

Mr Boschetto: Thank you.

The Chair: I will just say to committee members that we will adjourn for just a few minutes while we wait for the medical society. Is there a question, Mrs Caplan?

Mrs Caplan: I would like to ask a question of the ministry staff. I'd prefer that it be on the record in Hansard if you wouldn't mind.

The Chair: That's fine.

Mrs Caplan: The committee may remember—I believe it was in London—that I raised the case of a constituent of mine who's having some difficulty receiving appropriate care in the appropriate place or, as they would say, the right place at the right time. What I' ve been told is that at the chronic hospital where the person is right now, they' ve told this constituent that he must be an inpatient in order to receive the rehabilitation speech therapy service that he requires, and that if he does not sleep in the bed he's not entitled by ministry regulation to receive the care.

It was always my understanding that chronic hospitals were globally funded and that they had the flexibility to deliver services either inpatient or in whatever way, that the ministry didn't require head counts on a nightly basis to determine what the inpatient capacity was.

The reason that I raise this is that the people who were just here talked about that incentive being in place for nursing homes. I'm aware that this is the case and nursing homes fill the beds and keep them full. Does the same situation apply to chronic hospitals at this time?

Mr Wessenger: I'll let the staff answer that.

Mr Quirt: The short answer to your question is that I see no reason why a chronic hospital would be required to have a policy that allowed for specific therapy services to be provided only to inpatients. As you are well aware, the position of the Ministry of Health is to encourage hospitals to look at how they deliver services generally and become more of a resource to the community, and try to do more on an outpatient basis if that's the appropriate way to deliver services to that particular client.

Mrs Caplan: So the ministry would have no objection to this patient receiving a nightly pass so that he could sleep at home and still be entitled to the inpatient service? You would have no problem if the hospital administration wanted to allow this person to sleep at home?

Mr Quirt: I don't know the individual circumstances or the particular hospital in question. There may be an entirely different point of view from their end of it. In general terms, I don't think the Ministry of Health has a policy that would preclude someone receiving hospital services on an outpatient basis. As a matter of fact, in general terms, we would encourage that. If you'd like, we'd be happy to look into the individual circumstances, by my colleagues in the community hospitals branch. They would provide you with an answer specific to that particular facility and the concern you've raised.

Mrs Caplan: I don't want to belabour the point. The reason I want to have it on the record is to make sure I've heard clearly the advice that you've given me, and that is that you cannot think of any piece of legislation or any regulation that's in place right now that would require this person to sleep in the bed in the hospital in order to be able to receive the service he requires from that chronic care institution.

Mr Quirt: I am not aware of a regulation. There may well be one that I'm unaware of, but I'm not aware of one myself.

Mrs Caplan: But would you say that given the policy direction you've just announced, which is that this government and the government before was encouraging hospitals to allow for greater shift to outpatient and ambulatory and flexibility, it's your view that the ministry would not in any way penalize this hospital if it permitted a patient to remain classified as an inpatient if he didn't sleep in the bed at night?

Mr Quirt: I am unaware of any regulation that would penalize a hospital for specifically that. I would remind you that I'm not an expert on the acts that govern acute care facilities and if there's a particular concern with this—

Mrs Caplan: Chronic care facility.

Mr Quirt: Well, it's the same bill that funds them both. I would be happy to find out more specifically what the problem is in the particular circumstance that you're raising and get you a more complete answer from someone who is more familiar with the acts and that program.

Mrs Caplan: Thank you. My question of the Chairman or perhaps of the clerk is whether there's any flexibility in tomorrow morning's schedule in Toronto. Do we have any time or is it totally booked?

The Chair: It's totally booked.

Mrs Caplan: Okay, thank you.

The Chair: Mr Wessenger, did you—

Mr Wessenger: I was just going to indicate to the member that if there's a problem in this regard, I'd like to know the specifics and be able to follow through, because certainly the policy is to provide ambulatory care. The policy is to provide care for the people in the community and it doesn't seem to make sense in overall health strategy if there's a refusal to provide those types of services.

Mrs Caplan: I actually suggested to the medical chief of staff in this particular chronic care hospital that they allow the patient to leave a teddy bear in the bed and let him sleep in his own home at night if they had an obligation to keep the bed full. he said that they were concerned about reprisal from the ministry or that they would not be meeting regulations. So I wanted to clarify that today.

The Chair: The committee will stand adjourned briefly. If members could just be present, we're just trying to find out what has happened to our last presenter.

Mr Bisson: It's past 3 o'clock, Mr Chair.

The Chair: I appreciate that, but we're here and we can wait for a bit. Our van won't be here until a little later. So we'll just have a brief recess.

The committee recessed at 1507 and resumed at 1517.

The Chair: Members of the committee, because of our schedule today and flight arrangements, we've not been able to make contact with the 3 o'clock presenter, but it being now—

Interjections.

The Chair: We thought we spied one of the presenters, but I'm afraid at this point I'm going to have to close our hearings today; otherwise we will not be able to make our flight. With that, I want to just say that we thank all the presenters, not only from Sudbury but from North Bay, the Sault, Espanola, Timmins and other areas who have come down today. We've found, as we have, I think at every location, a great of substance in the presentations that were made. The committee will certainly be considering those carefully. We want to express our thanks to everyone in this area for coming. With that, the committee stands adjourned.

The committee adjourned at 1518.



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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Witmer, Elizabeth (Waterloo North/-Nord PC)

Substitutions present / Membres remplacants présents:

Bisson, Gilles (Cochrane South/-Sud ND) for Mr Drainville

Caplan, Elinor (Oriole L) for Mr Daigeler

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mr Jim Wilson

Marland, Margaret (Mississauga South/-Sud PC) for Mrs Witmer

Wessenger, Paul (Simcoe Centre ND) for Mr Gary Wilson

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service

^{*}In attendance / présents







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Tuesday 23 February 1993

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Mardi 23 février 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée

Chair: Charles Beer Clerk: Douglas Arnott Président : Charles Beer Greffier : Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 23 February 1993

The committee met at 1014 in committee room 2.

LONG TERM CARE
STATUTE LAW AMENDMENT ACT, 1993
LOI DE 1993 MODIFIANT DES LOIS
EN CE QUI CONCERNE
LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): I call this meeting of the standing committee on social development to order. Just before we begin with our hearings, I note for members of the committee that legislative research has just put together some articles from the weekend papers on the question of long-term care for our information. Some of you may have seen them, but as often happens, one misses them.

ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS

The Chair: We've had several cancellations this morning for a variety of reasons, but I thought as the Ontario Association of Residents' Councils, which was to begin at 10:30, is none the less here, it would be useful if we got started. That way, we can even give them a little more time, which I think would be useful for all of us.

With that, could I call upon the representatives from the Ontario Association of Residents' Councils to come forward. We're delighted you could fight through the snow and whatever else lay out on the roads to get here and be with us this morning. Help yourself to some Toronto water, if that appeals. Please have a seat.

Mr Peter Kehoe: My remarks will be very brief, and I feel quite at ease standing.

The Chair: Our problem is for electronic Hansard. I'm afraid it's one of those encumbrances of modern time. Would you also be good enough just to introduce yourself again for Hansard and for the members.

Mr Kehoe: I will. Good morning, ladies and gentlemen, honourable members. On behalf of the Ontario Association of Residents' Councils, it's my pleasure to be here. I'd like to introduce myself. My name is Peter Kehoe. I'm the president of the association and I'm a resident of Rotary Laughlen Centre, which is a long-term care facility. It's a charitable care facility in downtown Toronto. To accompany me this morning we have our executive director, Mary Ellen Glover, and our research director, Miss Pat Prentice, both of whom are paid employees.

The Chair: Would you like them to be at the table with you?

Mr Kehoe: They will in due course. Mary Ellen Glover will present the brief on behalf of the association.

Also accompanying me this morning are four members of our executive. They will be available to answer questions as they may arise after the brief has been presented. We've a fifth member of the executive, a woman who is physically disabled, who is unable to be present this morning. She's a person we would be proud to have with us. She's a very competent individual, but she has difficulty getting around. She represents the women in our constituency, who are a significant number of the residents in long-term care facilities.

By way of introduction, I would say that the Ontario Association of Residents' Councils is made up of councils in long-term care facilities and speaks on behalf of the residents in these homes. Our function is to interpret for the residents the views put forth by the management of the facilities, the information that's given to us by the government through the various departments and also to interpret back to the management of the facilities and to the government the views of the members we represent.

With respect to long-term care, we feel we speak on behalf of about 25,000 people who are presently living in these facilities. We also speak on behalf of their dependants and next of kin and those in the community who may one day be in long-term care facilities or who may wish to consider that as an alternative way of life as they advance in years. So our constituency is a large one.

In general, our reaction to the proposed changes in long-term care are positive. We can quibble over details and there are many things about the proposed changes that we would like to alter, but on balance, we feel pleased to see some action being taken. We would like to feel whatever changes are being made will be made on a trial basis and they will be subject to revision based on experiences that may develop over the years.

There are two or three points I'd like to make just before I turn the meeting over to Mary Ellen Glover, our executive director. The first point is, we are concerned about access to facilities. We recognize that long-term care is an expensive, limited resource that has to be available to the community on a need basis. We would like to feel the need of the individuals concerned is recognized in a holistic way and also, apart from taking account of their physical and mental capacity, recognizes their personal preference with respect to ethnic, cultural and religious background. That involves of course an appeal process and the like.

Once they're in the facility, we are concerned about the quality of life and the quality of care. We feel these are very important elements and we feel they need to be monitored because of the substantial amounts of money involved in providing this care. For that reason, we feel some kind of inspection process is warranted.

We're also concerned about the financing of the whole operation. We recognize that finances are a vital and important part of the continuing supports in the community. Apart from being supported by the taxpayers at large, those who are enjoying the benefit must be able to contribute as far as their means permit. We also feel that those who are able to pay more than the minimum should be expected to do so if they want preferred accommodation.

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We are concerned with the long-term financial stability of the institutions in which we live, be they charitable organizations, such as the one in which I live, or others. We feel they must have some secure, dependable source of income that's going to give the residents assurance of their continued efficient, effective operation. Those are my general comments.

Our executive director has prepared a brief and we feel quite confident that she's able to present it to you on our behalf. Following her presentation, if there are any questions you wish to direct to either Mary Ellen Glover, the executive director, myself or the other directors who are here this morning, we will be pleased to do what we can to answer your inquiries. Thank you for your time and attention.

The Chair: Thank you. Perhaps you would care to remain there, because after the presentation we'll move to questions. Ms Glover, welcome to the committee. Please go ahead.

Ms Mary Ellen Glover: Thank you for providing us with this opportunity. As Mr Kehoe has noted, our association is governed by a board of directors elected from and by residents in our member facilities. Pat Prentice and I are the only two people associated with the organization who are not residents in long-term care facilities.

We provide our services to both members and nonmembers, and when we are faced with an issue such as long-term care reform, we solicit information and opinions in the following manner: We solicit them through questionnaires such as that in our report, Long Term Care Reform: The Resident Perspective; we solicit them through regional conferences, through meetings of our board and executive at which items of concern to residents are discussed and policy set, and through personal visits to individual homes and groups of homes.

We also work in cooperation with other organizations concerned with residents and their welfare, be they other consumer organizations or care providers, to ensure that the rights and dignity of residents are protected.

We have participated fully in discussions on long-term care reform from the original initiatives developed by the previous government through to participating on the working group which worked to develop the standards of care that will come into effect with this legislation. We are pleased to see that some of our recommendations have been accepted, however we still have some serious concerns about the reform process and its consequences. Therefore, we wish to comment briefly on the following aspects of the reform.

First of all, we'd like to talk a little bit about residents councils and their right to exist. Currently, the only piece of legislation that recognizes the right of residents to form a residents' council is the Nursing Homes Act. It requires

that administrators of nursing homes inform residents of their right to form a council and specify some limited powers. No such requirement exists for homes for the aged, whether they be municipal or charitable.

While the requirement to inform under the Nursing Homes Act has not resulted in all nursing homes having an effective residents' council, it has increased the awareness of the need to have residents' councils. Where homes have taken the responsibility of forming a residents' council and providing it with appropriate support mechanisms, these councils have proved to be an effective liaison between the resident population and the management of the home.

We are disappointed that Bill 101 does not recognize residents' councils and the need for them in all forms of long-term care facilities. We feel this is perhaps a step backwards for a province which under all governments over the past 15 years has recognized the need for a vehicle in long-term care facilities that will lead to resident empowerment. In fact, the province of Ontario has shown itself to be so forward-thinking that it is the only Canadian province which has recognized the need for an association such as OARC and provided it with financial support.

During the consultation process, many organizations other than OARC supported the idea of greater recognition of residents' councils. Even Dr Ernie Lightman in his report on rest and retirement homes recommends the establishment of residents' councils.

We would therefore recommend that some consideration be given to formal recognition of residents' councils in legislation. As well, we would recommend that standards or regulations outline mechanisms that should be put into place within homes to support the council and its activities.

We also have a serious concern about the placement coordinator aspect of the legislation, the powers of the placement coordinator and the appeals process. In our original brief, we dealt with the concept of a service access coordinator and we were certainly in favour of such an agency as a central information agency. However, we did have some grave concerns about the ability of such an agency to take into account the wishes of the individual.

These concerns have increased after looking at the powers given to the placement coordinator in Bill 101. We are extremely concerned that this placement coordinator will literally be given the power to control the individual's life. Not only will the placement coordinator decide who is eligible for admittance to a long-term care facility, but he will also decide who will be admitted to what facility. What guarantee do we have that this power and authority will not be abused? It would appear there is indeed no guarantee.

In our original brief, we pointed out that there are seniors who do wish to live in a communal facility, to be with peers, to have the opportunity to socialize and to feel safe and secure. Will the placement coordinator recognize these as valid reasons for admission to a facility?

Again, not only have our members told us that they wish to live in a communal facility, but they have told us that for the most part, they very carefully selected a specific facility. They didn't just enter the one which was

closest to where they lived or take the first bed that came along. What regard will be given to the individual's wishes to live with others of the same religion or ethnic background or indeed to live in an all-female residence?

Currently, we often face the situation where a hospital discharge planner almost threatens the senior or family members by strongly implying that a senior who must go from hospital into long-term care must take the first bed available or they will be put out on the street. Will the placement coordinator alleviate or aggravate situations like this?

Our concerns about the powers of the placement coordinator arise partly from what we see as the result of Dr Ernie Lightman's report, A Community of Interests. Dr Lightman made recommendations which he felt would help people. While I'm certain he was well-intentioned, his report reflects his opinion and the recommendations are his. It does not reflect the consensus of a group, and in reality it ignores the needs of a good portion of the senior population who live in retirement homes. He has actually put forward recommendations which could harm rather than help these people. Will the same thing happen with the placement coordinator? Will it be "Do this because I think it is best for you" rather than "What do you want to do?"

Not only would it appear that the placement coordinator—he, she or they—has the power to literally play God, to decide what quality of life the individual will or will not enjoy, but it would appear that there is no realistic avenue of recourse open to the individual. Yes, there is an appeal process. If the individual does not like the decision of the placement coordinator, he, she or their representative can go to the appeal board. If they don't like the decision of the appeal board, it's on to Divisional Court.

How realistic is it to believe that your average frail 85-year-old widow will be able to follow such a process through on her own? Is it even realistic to think that your average family member could follow the process through without some assistance from an advocate or even a lawyer? Where will this assistance come from? Yes, the advocacy legislation has been passed. There will be an advocate to help the consumer, but what will happen in the period of time between the implementation of this legislation and a full-fledged advocacy system being in place and working?

The legislation specifies that one member of an appeal board may be a physician. That's fine, but who will be the other members? What about provisions for a consumer representative or an advocate?

Many of our members have come to us with concerns about the proposed copayment. The government has told us that copayments for people who currently occupy extended care beds will be increased under reform. First we were told it would rise to about \$35 per day. Then the rumour was \$37 a day. Now we hear that it will be \$38 a day. Now, ladies and gentlemen, tell me what would you say if your mortgage holder or your landlord told you that your monthly payment was going to increase by approximately \$360 per month. It would be an awful blow, wouldn't it? Perhaps Dr Lightman's comment made to the conference on long-term care sponsored by the Institute

for Law and Medicine that even nursing homes should be covered under rent control was not so off the wall after all. At least residents would have some protection.

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It would appear that long-term care reform is being paid for by residents. It would also appear that residents have, at this time, no guarantee that they will be getting a bigger bang for their buck. We are still not certain if they will be getting more service, higher quality service or if in effect they are only being charged an increased user fee which will simply go to finance the system in place. On a very basic level, this just isn't fair.

We also have grave concerns about the ability of the current resident population to pay this increased fee. While we applaud the fact that subsidies will be provided to residents who cannot pay the full copayment and that testing will be based only on income and will not include assets, we wonder if the government has a realistic idea of the disposable income available to the resident population.

Several years ago, we did a survey of our membership to determine what residents who depended on the comfort allowance bought with their very limited disposable income. As a side effect of this survey, we also discovered there were many residents who did not depend on the comfort allowance but still had only very limited incomes. They came from a time when private pensions were limited or non-existent. Many women never worked but married and depended upon their husbands. When their husbands died, their pensions died with them or were reduced drastically. We wonder if this increase in copayment will result in the revenue projected or will it simply mean that more people are subsidized to a greater extent.

Putting aside the financial implications of the increased copayment, what will it mean in human terms? The human side of it is that an unknown number of residents will be forced to move, perhaps not change facilities, but move from preferred accommodation to less desirable accommodation. Has the government considered the situation of the 67-year-old nurse from Whitby who has a 90-year-old mother? Mother has been in the nursing home for five years and daughter is subsidizing her. Daughter is paying the preferred accommodation charge for a private room. This room has been mother's home for five years, but now mother must move because daughter cannot pay the increased copayment and the preferred accommodation charge. This is a true story. This is not what if, this is a real question that was asked to our office.

I guess the other side of this question is the facility's side. What happens when people come and request a change in accommodation from perhaps preferred to ward? How does the facility juggle accommodation? Where do they find the cheaper accommodation and what do they do with possibly empty beds?

Lastly, we have some very minor concerns about the powers of inspection that were listed in Bill 101. Over the years, we have received a small but steady stream of complaints from residents' councils about the inspection process that was in place in the past in nursing homes. These complaints range from complaints about how individuals

are treated by inspectors to complaints about how the group residents' council is treated.

There are two aspects of this legislation as it applies to the rights of inspectors that concern us:

First, it specifies that inspectors have the right to question a person on matters relevant to the inspection. But, we ask, what about the right of the individual resident to refuse to be questioned? Many residents find the inspection process intimidating. They feel they are being inspected and judged.

Again, the legislation specifies that the inspector "may demand the production for inspection of records or other things relevant to the inspection." We have encountered instances of the inspector demanding access to residents' councils' records, and when being given access, telling the council that its records are not appropriate or kept to the satisfaction of the inspector. It must be made very clear that it is not the council's records that are being inspected. What should be checked is the home's response to council requests. Council records should be the property of the council and it should be clear that the council has the right to decide who sees those records.

In conclusion, we would like to comment briefly on the consultation process. The government has provided many opportunities for consultation. They have asked consumers what they want changed and how the system should work. They have asked consumers to sit on committees. Consumers are doing this, often giving a great deal of their own time and often at their own expense.

It was very difficult for all of us to get here today. One of our members had to come from Ottawa and one of them had to come from Kingston. The weather was certainly not very good yesterday, but we made it.

The government is getting a lot of free consultants, but often these consultants are coming away with the feeling that this whole process was just a sham, that we are giving but not getting, that the decisions have already been made and that all this is simply window dressing.

On behalf of our association, thank you very much for this opportunity.

The Chair: Thank you very much for coming in and for your detailed brief. We appreciate that. We have had a number of individuals who have been before the committee, sometimes with other groups, who have spoken on behalf of residents, but this is the first time we've had the council. It's an area that has been of interest to members of the committee, so we're delighted to have you with us this morning. We'll begin the questioning with Ms Marland.

Mrs Margaret Marland (Mississauga South): Good morning, Ms Glover. I would like to congratulate you on making the effort to make a presentation to this committee. I was sitting here thinking that I hope Mr Jamison isn't intimidated, because I've been in the Legislature eight years and it's the first time I've sat on a committee with five women and one man.

Mr Norm Jamison (Norfolk): That's exactly the number of women who are in my house.

Mrs Marland: So you feel comfortable.

The Chair: There are a few of us guys up here too, you know.

Interjection: They don't count.

Mrs Marland: It's a coincidence that there are so many women sitting on this committee this morning. The reason I mention that is that in my experience of 20 years in politics, I think these kinds of issues are very often ones that for some reason we end up being closer to. I think it comes from the fact that, if we look after family members in our homes before we become involved with different forms of long-term care, it has been traditional that the women have been the care givers in most cases. I think it's great that the representation on this committee this morning, when you're here, is as it is.

I want to say that I have some experience with a residents' council at the Mississauga Hospital, which is currently chaired by Kathy Harvey, who is a constituent. Her family have been constituents of mine. When I went to the public meetings that residents' council held to look at the discussion paper of the ministry, I heard a lot of the concerns you've addressed this morning. I think Kathy Harvey herself is an example. I think she's maybe 46 or 47 now, and she's a multiple sclerosis patient who has had to live in the hospital since she was 34.

When I look at the category of patients who are from that particular residents' council, I realize we're looking at a whole range of needs when we deal with the subject of long-term care. It concerns me that long-term care in this particular Bill 101 never addresses chronic care. I can't ever begin to understand why the Ministry of Health thinks it could separate the two between long-term care and chronic care.

Also, I hear very clearly the concerns you're expressing about has it all been window dressing and is it a sham, because the only way we'll know that is if the bill goes through exactly as it is now. If there are no substantial amendments from the government to this legislation to address the concerns that have been brought before this committee through a number of weeks of public hearings, then we'll know it has all been window dressing and it is a sham. The government intends to pass its legislation the way it's drafted and we might as well forget about the public input process. I felt the public input process was ignored even with the drafting of the bill, after the response to the discussion paper.

You said, "Of course there will be advocates," and then you went on to talk about an Advocacy Commission. Because I don't have a copy of your brief in front of me, I'm trying to paraphrase what you said. If there's going to be an Advocacy Commission, do you have the sense that there's going to be a safety net out there? People's expectations will be that each and every one of them will have access to an advocate for their personal needs, and when the reality hits that there won't be an advocate for each and every person in need—do you have a concern for people whom your residents' councils represent, that the whole area of advocacy isn't going to help in their long-term care?

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Ms Glover: Yes. I do have a concern that the proposed advocacy system really won't help residents in long-term care facilities all that much. One of the things our association preaches when we go out to help a home set up a residents' council is cooperation, not confrontation. It's working together. Where you can get cooperation between the administration of the home and the residents' council, the council can do great things.

I have a bit of a concern that if things aren't worked properly with an advocacy system, it will be setting up a confrontational situation rather than a cooperative situation. That's the concern I have with that placement coordinator thing and the whole appeal process. You've got this person there who looks like he or she or it or they are going to play God: "You can go." "You can't go." "You can go in here." "You can't go in there." Then the person can appeal to an appeal panel, but we don't know much about that appeal panel, and that's a difficult process to go through. It would be difficult for me to go through it on behalf of somebody without some assistance.

If you're rejected by the appeal panel, then you get to go to Divisional Court. It seems to me to be just a little too much to expect people to take advantage of it without a great deal of assistance. I can give you examples of things that have happened, a couple of cases where residents in retirement homes have appealed against an increase in their monthly rate. They've had to have a great deal of legal assistance to be able to use the process effectively.

Mrs Marland: When you talk about the power of this placement coordinator, I should tell you that you're certainly reiterating a lot of comments that we have been hearing. If there's one pivotal point of concern, that's the one we've heard the most. I'm not sitting on this committee regularly, but the days that I have been here, there has been a lot of concern about that.

In fact, yesterday in Sudbury, it was rather interesting to hear that one of the questions was there should be two ways of appealing the decision of that placement coordinator, one for the client to be able to appeal, but also for the facility to be able to appeal in terms of, "In my facility, I can't accept this person because I can't give them the adequate care or the type of care," or whatever the needs are that are being met.

The other point that was made yesterday in Sudbury too was that perhaps there should be a guaranteed expediency dealing with that appeal, because you simply can't say 30 days. Thirty days from now may be too long for everybody who's involved in placing that individual. I wonder if you'd like to comment on the two-way appeal and the length of time it would take.

Ms Glover: I think it would be fair to say that our association would also feel that it's not only the protected resident who has the right to appeal, it is the home that has the right to appeal against taking an inappropriate placement.

One of the things we hear most often when we go around the province and talk to residents in individual homes is the difficulty that presents to fairly well residents who are alert and active, like the gentlemen who are with

us today, when they're constantly faced with the situation of having to deal on a daily basis, 24 hours a day, with people who are cognitively impaired perhaps or who are disruptive, I guess. It's very wearing on residents. So certainly the home should have the right to appeal, and if it's going to be any kind of a decent appeal process, it should be quick. I guess maybe that's another concern about this Divisional Court thing.

The Chair: If I can move on then. Ms Carter.

Ms Jenny Carter (Peterborough): Thank you for your presentation. There's one question I would like to ask you straight away. Do you think it would be a good idea if the act stated that residents' councils were to be compulsory in all facilities?

Ms Glover: I guess that would be a wonderful idea, but making residents' councils compulsory does not necessarily make residents' councils good. There has to be something in there that will assist in making residents' councils effective.

I'll give you a perfect example. This particularly applies to chronic care hospitals. They decide they're going to go for accreditation. The first thing they do is phone us up and say, "We want to become a member." This is so they'll get a membership certificate they can hang on the wall saying they're a member of the Ontario Association of Residents' Councils. This is so that when the accreditation people come in, they can say: "We have a residents' council. Look here, we're a member of that organization."

Ms Carter: The point is that it's obviously something that is very good to have, and I think we would all agree with that, but you really can't force it. It has to be spontaneous to be genuine.

Ms Glover: I think there should be something in there that encourages the home very strongly to develop and support an effective residents' council. When a nursing home looks at the act and takes that situation where they have to inform, they can do one thing or another. They can say, "Guys, you need to have a residents' council" or "You can have a residents' council," or they can sit down and put into the home some systems whereby the council will work.

We produced a video last year with the assistance of the Ministry of Community and Social Services and one of the councils that is in this video is a council in a nursing home. All the members of the executive are over 90. The vice-president is 96. They're all in wheelchairs. They have monthly meetings. They get maybe 50 to 60 people at each meeting. But the home makes sure that the aides take the people down to the meetings. The home has provided the council with a volunteer who acts as their hands and their feet. The council makes the decision; the volunteer goes out and implements the decision. This is the kind of support that would be effective.

Ms Carter: I am looking at this whole question of how we're going to ensure that there is a high quality of care in institutions. You mentioned that the Advocacy Act might not do a great deal, but it seems to me there is an interplay here that where you have a flourishing residents' council, maybe there wouldn't be much need for advocacy.

But maybe in a home where, for whatever reason, a residents' council was not functioning well or was not in existence, then that provides another fallback for individuals whereby they can get problems remedied. Of course, if enough people in a given institution did that, then the systemic side of advocacy would come into play, where a problem that affects a lot of people can be looked at and remedied.

Then, of course, there's the question of inspection, which you did mention. That has been raised before this committee quite frequently, that people don't like the idea of having these people coming in and looking. I'm just wondering what is the best sort of interaction between these three possibilities.

Ms Glover: Between inspection, advocacy and residents' councils?

Ms Carter: Yes. We need something in place there to safeguard residents.

Ms Glover: I don't think you can deny that there is some kind of an inspection process needed, but I think the idea that has been put forward over the last several years of compliance and cooperation between the governing agency, which is the government, and the administration of the home is the way it should go. Inspectors don't do bad things, but sometimes they can be rather insensitive to the needs of the residents. Sometimes they can say that the home has to do things that maybe the residents don't really want it to do.

I had a situation where the council phoned one time and they were all up in arms because the inspector said they could have apple pie only once every six weeks. They had been used to having it for dinner on Sunday.

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Ms Carter: The residents' input is very important to keep this on a commonsense basis.

Ms Glover: Yes.

Ms Carter: The other point I would like to raise is this whole question of the coordinators, because again, we've heard a lot about this and about how powerful these people might turn out to be and so on. Although that is not clarified in the act—I'm inclined to think it should be—the intention certainly is. I think if you look at the regulations and so on, you will see this. The coordinator would not act like that. He would put the consumer's choice very much at the top of the agenda as far as where that person would go. Things like ethnic differences, religious differences and so on would be respected and people, wherever possible, would go somewhere that was at the top of their list and was appropriate. So that certainly is the intention, although as I say, it doesn't seem to be very clear in the act.

Ms Glover: I suppose one of the reasons we have concern about this is that over the summer when we participated in the development of the standards that will be used, not only was our association concerned, as Mr Kehoe put it, that people be eligible for holistic reasons as opposed to, "You're old and you're physically sick so therefore you can get in"—because there are people who choose to live with their peers in some form of communal

setting. I'm not saying everybody does, but there are people who need to be considered. So we'd be looking at the standards and everybody on the committee would agree on certain wording. Off it would go to wherever it went and it would come back and the wording would not have been altered to reflect the concerns registered by the committee. This is why we're concerned.

Ms Carter: This is a universal concern.

The Chair: I'm afraid we're going to have to move on. Ms Fawcett.

Mrs Joan M. Fawcett (Northumberland): I too want to thank you for making the effort to come, because I think this is one group that we really need to hear from. Certainly, what you have said so far echoes what other people have been saying, but you've even gone a little bit further on a few things and I can certainly agree with you.

I have a 94-year-old aunt who is in a retirement home right now. Getting into the idea of the residents' councils, they boasted of having one, but absolutely it just died. It was more or less as you termed it, window dressing, because it seemed that any of the concerns of the residents just got lost and did not go forward. Certainly, one of the things she wants to know whenever she sees me is what's happening about these kinds of things and what we're doing.

When thinking of an amendment, I certainly liked your words "develop and support an active residents' council." I think that goes a long way. I don't know whether you have put your mind to an amendment that possibly would work in this legislation, because we fear, with so much that is going to be left to regulations, maybe we won't have a chance for the input. So we'd like to see some of these things that are concerning people in the legislation. Have you put your mind to a proper amendment that would say what you want it to say?

Ms Glover: No, we haven't, but we're having an executive committee meeting this afternoon and we could certainly put that on our agenda for other business.

Mrs Fawcett: You might just want to consider that, and certainly we'd be interested to know just what you would come up with.

We too wonder about the copayment system, because as most facilities have expressed to us, we don't know what the formula is going to be and we keep hearing rumours. Now we're told that hopefully we'll know at the end of March, and that's coming soon. It's put a lot of facilities on tenterhooks, because they don't know just what it is they're going to be doing. So we certainly appreciate you coming in. I have other questions, but I know my colleague would like to ask just a short question as well, if that's okay.

The Chair: Okay, a very short question.

Mrs Yvonne O'Neill (Ottawa-Rideau): It's more of a comment. I'm very pleased that you told us the specifics of your problems with the consultation process, because we feel the same way; that although this document is touted as having the highest level of consultation ever, the consultation took place previous to the legislation, and

many are telling us that they don't see the results of that consultation here.

Everywhere we've gone, the residents' councils have been more than helpful, you'll be happy to know, and we have found many presentations that were joint residents' councils and administrators, and as you say, the cooperative model certainly is one we all aim for. So I think you can keep up the good work. I'm glad you're going to put us on the agenda of your meeting this afternoon.

The Chair: The parliamentary assistant has a couple of points in response to your brief, and if, in return, you wish to ask any questions of him or of staff on those, please feel free to do so.

Mr Paul Wessenger (Simcoe Centre): Thank you very much for your brief. I just thought I'd clear up a few items and then ask staff, also, to clarify a few more. First of all, with respect to concern about the legislation, there is likely to be a second phase of legislation with respect to the community aspect of long-term care, so hopefully if there are any corrections that need to be made, we'll have the opportunity to do that at that stage as well.

Mrs Marland: Would you explain, Mr Wessenger?

Mr Wessenger: We have a policy statement coming out in the month of March with respect to long-term care.

Mrs Elinor Caplan (Oriole): Don't hold your breath.

Mr Wessenger: Likely, there will have to be legislation prepared to integrate based on the policy statement. For instance, one example of course is the role of the placement coordinator, which will relate to community care as well as institutional care.

Mrs Marland: I have a point of order, Mr Chairman.

The Chair: Point of order.

Mrs Marland: My point of order is this: The parliamentary assistant said there would be a second phase of legislation, and I asked him to explain it because I didn't want anybody in this room to not be able to understand that; I certainly didn't. Now in explaining it, he backs down and says, "Well, there will be a policy statement, and there probably will have to be legislation to enforce the policy statement." I think, in fairness, on a point of order, the parliamentary assistant, speaking on behalf of the minister, should say one thing or another.

The Chair: If I might preface, the parliamentary assistant is speaking to the points. I understand your comment, and the parliamentary assistant's comments will have to be taken as they are given.

Mr Wessenger: The second point I'd like to deal with is with respect to the question of residents' councils in all long-term care facilities. I certainly agree with you that all of the long-term care facilities ought to have residents' councils, and certainly I'll be recommending that legislation be amended with respect to all the long-term care facilities to ensure that this occurs.

Also, with respect to what Mrs Fawcett raised, we certainly would appreciate your recommendations as to how we could make residents' councils more effective, and I'm pleased to hear it's going to be on your agenda so that you can respond to that aspect.

With respect to your concerns about the lack of a holistic approach concerning the admission criteria, I assume that was based on the first manual draft, which did, I understand, relate basically to personal and nursing care requirements. There is a subsequent, second draft. I don't know whether it's out yet, but if it isn't, it will be out very shortly. I hope you'll review it, and I'm assured it will take account of social factors as well as just the personal care factors

On the question of placement coordination, I think I'll ask ministry staff to explain again, because there has been a fair amount of misunderstanding with respect to that. I can assure you the intention is to ensure consumer choice, and I can also assure you we are looking at ways to make that clearer in the legislation.

Mr Geoff Quirt: I'm Geoff Quirt, acting executive director of the long-term care division. As Mr Wessenger said, the proposed placement coordinator's job would first of all be to determine whether a prospective resident was eligible for admission to a long-term care facility and to allow consumers, the prospective resident or his or her family, in that context to make an informed choice with respect to the community service options they may not have been aware of and also an informed choice about which long-term care facility they would choose to go to. Many prospective residents currently would not know what resources were available in their communities, so the placement coordinator's job is to make sure they understand that and to make sure that they get fair access to the facility of their choice.

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In other words, once the prospective residents indicate which facility they wish to go to, then their access to that facility should be based on whether they need to go to that facility more than someone else who has expressed a preference for the same facility. So the notion of client choice is of paramount interest to us in that context, and as Mr Wessenger said, we suspect that amendments to that effect would be coming forward for the bill.

The second point I'd clarify is with respect to legislation. As you're well aware, the bill before the committee, Bill 101, amends a number of pieces of legislation: the Nursing Homes Act, the Homes for the Aged and Rest Homes Act and the Charitable Institutions Act. It's our hope to proceed with a more comprehensive piece of legislation that would replace those bills. This bill before you simply amends them, and the consistent standards that are being put into each of those three bills would form the basis of a larger reform replacing those bills and also providing, in that second piece of long-term care legislation, the legislative framework necessary to implement community service reforms as well. An example would be the creation of multiservice agencies.

So we do intend to proceed with the second phase of legislation to consolidate existing bills or legislation that relate to long-term care facilities, and also, in that second phase of legislation, to provide the framework for community service improvements as well.

The Chair: Any comments, questions or thoughts that you want to make on that at this point?

Mr Kehoe: I would like to volunteer a couple of remarks before we conclude. With respect to the question regarding the Advocacy Act that was raised by a member, we rightly or wrongly look on the Advocacy Act as a means of ensuring the rights of individuals as it's providing a safeguard for the individuals. We feel the residents' council function should be to look after the group and to avoid getting entangled with individual problems. We sometimes flip from what we think is our mandate, but if we're doing what we think we should be doing, we're concerned with the overall welfare of the residents in a particular facility and we try not to deal with individuals per se. We'd rather like to feel that we're dealing with policy matters that affect everybody.

With respect to the residents' councils, we feel quite strongly that a facility is better if it has a well-run residents' council, but it's a very difficult thing to legislate because unless the management of the facility is convinced that the time is worth the effort and that it will be able to improve things significantly by devoting the necessary time—and it's a considerable amount of time, because many of our residents are past their peak of productivity; they're very frail and that makes the task even more frustrating. But if the management is convinced that a residents' council can be effective, we think that the rewards can be significant.

But the mere fact that it's legislated is not in itself going to convince the management. They can go through the motions, and if they're not enthusiastic about it, the thing's going to be a failure, and we see that all too frequently. But if the management is convinced that it can do a good job by enrolling the efforts, although they're diminishing, of the residents in trying to provide for their own wellbeing, a residents' council can be a very effective device, and it can contribute significantly to the long-term quality of life for the residents and also, we think, to the efficiency of the operation.

It can develop a rapport between the management and the residents, which can go a long way towards overcoming many of the frictions which make life so miserable for so many people in these facilities, but the management has to be convinced that it's worthwhile. We think it can add to the quality of life, and we think it's one of the reasons why inspection is important. We like to feel inspection is about the same as going to the dentist: If you're in good shape, you've nothing to fear, but if you've got a mouthful of trouble, you hate to go. The ones who hate to go are the ones who usually need it the most.

In closing, I'd like to thank you all for your time and attention and the opportunity of being here. We appreciate the support we receive year-round from the department in our efforts, and we look to your continued goodwill in the future. Thank you very much for your time.

The Chair: Thank you, and may I, on behalf of the committee, thank the two of you as well as the other members who have come down today. As was noted, you're having an executive meeting this afternoon. If there is any-

thing from it that you would like to bring to the attention of the committee, we would be delighted to have it. If you could make it available through the clerk of the committee, that would be very helpful. Thank you again.

CONCERNED FRIENDS OF ONTARIO CITIZENS IN CARE FACILITIES

The Chair: I call on our next presenter, the representatives from Concerned Friends, if you would be good enough to come forward. We have a copy of your submission. Please make yourselves comfortable. Welcome to the committee. We hope you didn't have to shovel too much snow to get here this morning.

Mrs Freda Hannah: I was stuck on the subway for a while

The Chair: Right. Everything is not working as well as it ought to. If you would be good enough, first of all, just to introduce yourselves to the committee members and for Hansard, then please go ahead with your submission.

Mrs Hannah: I'm Freda Hannah, and I'm the president of Concerned Friends. This is Eleanor Murphy, who is on the board, and we're both on the advocacy committee. Eleanor's been with the association for eight years, and I've been around four years.

Concerned Friends is a volunteer advocacy organization which has been working on behalf of seniors in the province of Ontario for 11 years. Our goals are to address the quality of life issues in long-term care residences, to work for constructive changes in statutes and regulations and, most importantly, to provide information to residents and their relatives concerning their rights and responsibilities under government legislation.

We commend the efforts of those who are responsible for the development of the new proposed standards and guidelines for the long-term care facilities. That probably sounds strange coming from Concerned Friends, but we were in on this from the very beginning, and we felt the original standards and guidelines were a great improvement over the last guidelines. They're not perfect, but we felt they were addressing a lot of the problems that we deal with through the year. We only hope they won't be changed, with all the input, so much that we won't recognize them. I believe in input, but I hope the grass-roots problems are going to be addressed.

The amendments in Bill 101 show a determination for the progressive restructuring of the long-term care system in Ontario. As with any major change in a traditional and ingrained system, the transition period may prove to be fraught with unseen difficulties. In some instances, the impact on the consumer of acknowledged difficulties will be underestimated. Concerned Friends has reviewed the amendments, and we submit our comments and recommendations regarding the following areas, and we've just listed those in the bill.

Subsidies: We support the equalization of subsidies to long-term care facilities. Subsidies for seniors must be clarified and made public. A concern has been expressed repeatedly by seniors who call us that the phase-in period of this plan may cause unexpected financial, and thus emotional,

hardships for seniors in residences and those on waiting lists

There is an increasing fear among some families as to the eligibility of their relatives for subsidy. Residents whose copayment will increase by approximately \$330 a month, or \$11 per day, will benefit from a graduated scale of increase to the maximum over a period of time. This will allow for an adjustment period to a lifestyle with less money. We're looking here again at little problems like will they have enough money to pay a podiatrist, to have their hair done, to buy gifts for their grandchildren and families and so on. This may have a big impact on a lot of seniors.

1110

Service agreements: We support the service agreement as a comprehensive tool to increase the factor of accountability for service delivery.

Control of admission and placement coordinators: The development of centralized access and controlled admissions by a placement coordinator is a progressive step. We do however have strong recommendations for this area. The coordinator must be well trained in the process of assessment in the areas relating to social, psychological, emotional and physical needs of seniors. The components of case management should be examined carefully to ensure that seniors and their representatives do not fall into gaps within this new system.

The bill is unclear as to how extensive the range of case management tasks will be. So we recommend:

- Clarify the responsibilities of the parties concerned should a placement break down. For example, a senior who has Alzheimer's disease may suddenly become aggressive and abusive when placed in a long-term care facility where there is noise and confusion. If the facility is unable to adjust to his or her behaviour and it results in harm to this resident or others, who will resume the case management responsibility?
- Clarify the rights of the families within the appeal process to ensure both fair representation of their concerns and a full and satisfying quality of life for the resident.
- Define the lines of accountability, for example responsibility and reporting, regarding the placement coordinator.

Concerned Friends emphasizes the need for the improvement of the placement process because of the 11 years of continuous complaints about the current process. This following scenario is one that we deal with over and over, and I've just gone through this within the last two weeks with several families. This is where a person is now in a hospital, probably had a stroke or a broken hip, and the senior has made no plans for the future.

A hospital team determines that a senior would be better served in a long-term care facility. The family, if there is one, is notified. The discharge planner gives the family a list of available facility beds. The family visits the facilities on the list. The family's unable to find a suitable home. Now, by "suitable home" I'm not talking about the Ritz. I'm talking about a place that's clean, there's kind staff and they're made to feel at home—well, similar to home. The family, of course, examines each one carefully.

The discharge planner informs the family that they must move the relative to the first available bed or they may be charged the per diem hospital rate. If the senior has no family or representative, the hospital will transport the senior by ambulance to a bed, and that's the first available bed in a long-term care facility.

This causes overwhelming strain and frustration for most families, because they feel there is no choice. They must take what's there whether or not they are going to be happy there. It may not even be in their area. This is one reason why there are so many unhappy residents and families in long-term care.

Quality assurance plans: The ministry should add a procedure whereby external parties, such as family members and/or representatives, residents' councils and/or members of a professional body such as advocates, be incorporated into the quality assurance committees.

We note that quality assurance plans are an essential factor in monitoring the plan of care and ensuring that standards are met. However, we wish to stress that these plans can often become merely well-documented guidelines for service delivery and operations. That means they may look great on paper but they're not really being carried out in the hands-on care. The self-monitoring system can become weakened by time constraints and vested interests.

Waiting for accreditation councils and compliance officers to uncover the weak points in the system seems to us to be putting the residents' interests in jeopardy if for example the problems go unnoticed by the inspectors for six months or a year.

The external parties should also be given authority to take standards or quality assurance issues forward to an external committee of the district health council when their concerns are not being noted and acted upon at the quality assurance council.

Plans of care: We agree with this amendment, however the definition of "resident" must include "representative"; for example, "resident/representative." We, Concerned Friends, have discussed that many, many times when we've been sitting on committees. This would ensure that an individual with severe impairments would have the right to be represented by a friend, a neighbour, a family member or an advocate.

Staff must meet the minimum standard of literacy in order to implement an individual plan of care. This is essential in a multicultural society.

Inspections and sanctions: This is where we take a hard-nosed approach compared to other groups. The proposed monitoring system is satisfactory as described if it is implemented effectively. Some facilities appear to comply with the regulations, others have been in flagrant violation of the regulations to the detriment of care, comfort and quality of life and adding to potential risks of life.

We recommend:

 Rotate long-term care advisers/inspectors at least every two years to avoid relationships that may develop between inspector and service provider to the detriment of residents' welfare. Families often fear reprisals against their relatives or loss of residential placement if they voice complaints without anonymity.

— The residential services branch should conduct a consumer satisfaction survey as part of its annual review. These questionnaires should be sent to families and/or representatives prior to the on-site inspection. These confidential responses should be returned to the residential services branch. This will provide accountability to the consumers by providing a profile of the quality of care provided by individual facilities.

We support the sanctions described in Bill 101. We would add the following:

— Fines should be graduated in amounts to recognize the seriousness of violations as they relate to residents' safety, care and comfort, and should be increased in amount for each day of non-compliance.

— Notice of enforcements should be reported to residents and families and published in the local newspaper. The general public would be made aware of conditions in their local long-term care facility.

— Invoke the Health Facilities Special Orders Act, 1983.

When governments, federal, provincial and local, truly endorse the full spirit and intent of their legislation, standards and guidelines, when all owners, staff and unions of long-term care facilities make a concerted effort to provide a service that ensures the dignity of full quality of life for residents, then long-term care facilities will provide a viable residential choice in the community.

I want to thank you for the opportunity to present our comments and recommendations on behalf of the residents and the representatives whom we have assisted in long-term care facilities.

The Chair: Thank you very much for coming before the committee today for your brief. I think many of us have links with members of your organization in our own areas and we're delighted that you could be here today. We'll begin our questions with Mr Owens.

Mr Stephen Owens (Scarborough Centre): Welcome, Ms Hannah and Ms Murphy. Nice to see you again. The scenario you outline on page 3 of your brief almost sounds like a case that's come out of my office. You're absolutely right that in many situations people are being devolved from hospitals with little choice in where they go. The one thing that is missing here is the threat from the hospital that if they're not out by such and such a date or time, they—the patients and their families—will be charged an exorbitant rate to stay.

A little bit further down you talk about quality assurance plans. I heard a phrase yesterday when we were in Thunder Bay, "total quality management." Does this mean anything to you?

Mrs Hannah: Oh, there are so many. That probably means the same thing.

Mr Owens: In terms of care for the seniors in residence, not only seniors but other residents of long-term care facilities, what does that actually mean? Does it mean anything to you other than a new management buzzword?

Mrs Hannah: Yes, it is a buzzword. I have to say that, I think. However, if the plans can be set up and if they're fully operational and the staff will understand these plans—this again requires staff training. That is a big problem as well that we haven't addressed here but we certainly have addressed many other times. I understand there is a committee set up now, a resource committee, to look at standardized training for health care aides, and we have a board member on that. That's a step forward.

Mr Owens: Yes. I think you're right. You hit the nail on the head again on page 3 of your brief when you talked about the self-monitoring system that can become weakened by time constraints and vested interests. I think the message is quite clear. Based on some of the experiences I've had in my own riding, in which your group has rendered assistance, that is clearly the point that needs to be made. I'm certainly not a lawyer, but when I review the inspection process that's listed in Bill 101, it's by no means the most coercive inspection language that I've ever seen.

In your view, do you feel it's necessary that we have reasonably tough language around inspections so that we don't have to wait until a system becomes weakened until the system can respond?

Mrs Hannah: Yes, we do. For example, as we mentioned, some of the homes are well run. We know them. Of course, we don't hear from people who live in some of those homes.

Mr Owens: That's right. Exactly.

Mrs Hannah: We do know there are well-run homes and I don't feel they probably need this type of inspection, but for those homes that are constantly in violation—I review all of the compliance reviews where they have violations. I get that on every home in Ontario and it's not great reading. I look at those and quite often the same homes keep coming back for the same violations. They say they're going to change these violations, they're going to correct them, but they keep coming back over and over. We could name them actually. You can too, I'm sure, because we worked on the same places.

Mr Owens: As a matter of fact, I can.

Mrs Hannah: I think maybe more time should be spent on those homes. When I was sitting on the committees looking at the standards, one complaint that a lot of the administrators had was that they felt these standards were an insult to the staff, that they all know what to do. Our concern or our comment to that is: "Why worry about it if you're doing a great job? Don't worry about it. You know this. Leave this for the people who aren't doing a good job. They do need detailed guidelines for staff, at this point anyhow."

Mr Owens: I think that's an excellent point in terms of training. I think you may agree that it takes a special person to work in a facility that serves residents, whether they're seniors or other residents of long-term care institutions. I guess the challenge for the government is to make that job competitive in terms of salary and training, so it actually becomes a job choice rather than a place to make the rent money for a couple of years.

Mrs Hannah: That's right.

Mrs Fawcett: Thank you for coming today. Actually, I would like to pose a question on page 2, when you said, "The bill is unclear as to how extensive the range of case management tasks will be." I just wondered if the parliamentary assistant could help us out with that one question in the dark print there, "Who will resume the case management responsibility?" Should a scenario like this happen? Would you have clarification?

Mr Wessenger: Yes. Thank you for raising that issue. I'm going to have staff explain it. I thought of the same issue, so I appreciate your raising it.

Mr Quirt: The question is, who would assume responsibility for looking for an alternative placement for a resident who may have been appropriate when first admitted to the facility but acquired a need for a service that couldn't adequately be met in that facility? It would be the responsibility of the facility staff to alert the placement coordinator that an alternative setting might be necessary. The placement coordinator would assume responsibility then for finding an alternative placement if that was the appropriate way to meet that resident's needs.

I think it's important, however, to note that certainly our preference would be that every effort be made to provide services appropriate to the resident in that facility, the facility that presumably the resident had chosen in the first place, and the provincial consultative resources could be made available or other resources made available to allow the facility to meet its obligation to the resident it had admitted. Moving residents, because of a problem being encountered in their care, is a far less attractive option than equipping the facility to deal appropriately with the resident they have in their care and to provide them with the assistance they might need to do a good job in doing that.

Mrs Fawcett: Also, on the idea of inspection, we've heard from several people that the whole idea of inspection, policing, is really a step backward when you put it versus the continuous quality improvement that we would like to see going on, because if you just have a level that you have to meet then maybe you're not encouraged to make it better; and we can always make things better. We've certainly heard from numerous people who are doing a good job that they resent that whole inspection idea. I'm just wondering if you would like to further comment on that.

Mrs Hannah: I think to the extent the inspectors, if they aren't getting complaints from families and residents, know where the homes run well and don't, as you say, police them in the same way, they give them more time. They may not have to have an inspection every year, maybe every two years. That to them is a compliment, for one thing, that they're running a good home.

We have a report called the Report Card. If anyone wants a copy of this, you can look at our findings in 1990-91. As I said, I review all these complaints or the reports that come in and I can tell you that a lot of the homes just don't change, many of them don't. So therefore, I think these people have to have a different type of inspection, and they take advantage of the other system.

Mrs Fawcett: From what I could understand, this whole change to better qualit and always making something better—I mean, homes were getting better, whereas now they really feel that this is just an affront and that it's a step backwards.

Mrs Hannah: It could be with some of them, but I feel that if administrators and directors of nursing or care want to do more than the standards, and there's lot of room there, they could go ahead and do that. That's why we like the standards overall, because they are going to hopefully bring up the level of care in some of these homes that are poorly managed.

1130

The Chair: Mrs Marland.

Mrs Marland: First of all, I want to congratulate Ms Hannah and Ms Murphy. This is a very dynamic presentation that you bring to this committee today. We've just been handed your Report Card for Ontario Nursing Homes, January 1990 to March 1991. Just glancing through this, this is a very comprehensive report, and what a tremendous amount of work this must represent on the part of your organization. I wish something like this had existed in the 1970s when I had a family member to place. I really commend you as a non-profit volunteer organization for your kind of dedication. Concerned Friends is certainly the most apt name for the work that you're doing. I think it's just wonderful.

I'm wondering if you're experiencing a level of frustration with Bill 101 or whether you feel, overall, the people whom you've been concerned about in the past are not going to need you in the future. Do you have that much confidence in Bill 101?

Mrs Hannah: No. We'll always need advocates. Even in the best-run homes, there will be a need for advocates now and again.

Mrs Marland: As a volunteer organization that practices advocacy every living minute, how do you feel about having an advocacy bureaucracy with paid advocates now being established? How do you feel that'll impact your work on behalf of clients in long-term care?

Mrs Hannah: We're hoping it will lessen some of our work. We have no legal authority whatsoever.

I'll just tell you a little story. Last week I went into a home because a woman whose husband is living in this home was having a dreadful time. I won't go into the details, but I felt really badly about what was going on. She had tried to go through the system to talk to the administrator and the director of nursing, and she was told to call me or call Concerned Friends. So I went in, and her complaints were legitimate, for sure. The home found out that Concerned Friends were in there. So they summoned her to their office and told her she should not be working with Concerned Friends, she should be reading books on gerontology instead, and that she needed counselling because she was concerned about her husband, who had gotten outside, fell into a snowbank in his wheelchair and then later went down a flight of 15 steps.

I don't want to go in, and we don't like to go in, and be confrontational. I hate that myself personally; I don't like

that. I was prepared to go in and sit down and talk with the administrator and the director of nursing and try to settle these problems because I don't think the problems are huge. I think they can be settled, and this lady will be happy. But they treat her like a child and they're not going to give in to her. That's what it sounds like. You're concerned about advocates being confrontational; let's look at the other side, of the people who are in the homes.

I know the government will be training staff and administrators and so on regarding advocates and hopefully the residents are going to be informed as well or educated. But how many families are really going to call in advocates if they know there are going to be problems around it? So the advocates have no reason to be confrontational when they go in, absolutely none, because it's not going to help the resident at all.

The Chair: Final question, please.

Mrs Marland: We're almost out of time?

The Chair: No. go ahead.

Mrs Marland: In the example that you gave, the irony is that you could have been talking about—you weren't, but you could have been—my sister-in-law with my brother, just over a month ago. She was told she should be reading books, understanding and getting some counselling herself. So I guess some of these facilities—and this was a non-profit, government-run facility; it wasn't even a private facility that I'm speaking of—have the same lines. But it's a great deal of concern for the families, I know.

Mrs Hannah: Yes, it is.

Mrs Marland: On page 3 where you talk about this frustration of placement, you say: "If the senior has no family or representative, the hospital will transport the senior by ambulance to a bed in a long-term care facility."

"This process causes overwhelming strain and frustration for most families because they feel there is no choice."

This business of the placement coordinator and the choices of where, the location, the type of facility, the access for family members to be able to continue visiting and making the adjustment for the resident leaving home, perhaps for the first time and going into a facility, are not happy situations. They're not happy times. Do you feel that one individual, namely the placement coordinator making that decision, is too arbitrary?

Mrs Hannah: I don't know. It sounds that way, yes. But I feel if the family, and of course the family and/or friends or advocates, must be involved in this and have a say in this. I don't see it as the placement coordinator just simply saying, like they do now, "You go here." The big problem, and why it's hard to answer, is because there won't be enough beds to go around in the future.

Mrs Marland: Exactly, that is the problem.

Mrs Hannah: If the nursing home people who are residents who are now living in rest and retirement homes were to come into the nursing homes, into that area of the long-term care, they'd be overwhelmed with people. There just wouldn't be enough beds. That's where the problem is

going to be. It sounds great to be able to say, "You're going to have a bed in your community and if you can't get into that bed, you go into another home." I'm working with a case right now on this. You'd go into this other home and then when a bed becomes available, of your choice, you will go in there. But in all probability, you won't because there will be an emergency from the community who will have to have that bed, and you are in a bed, so that's where you'll stay.

Mrs Marland: That's right.

The Chair: Thank you. Parliamentary assistant, one point.

Mr Wessenger: Yes, I just have one quick question. You made a comment that you felt that some facilities take advantage of the system with respect to the existing compliance in the inspection system. I wonder if you could elaborate on that for the committee.

Mrs Hannah: I feel, when there are violations, the home is given time to correct the violations and they state how they're going to do it. But they don't always correct them and then when the inspector does a follow-up, the same violation is there or it may be corrected, but then in a year from now, when the annual review comes in, you find the same violations again.

Right now, if there's a shortage of beds, they tell families, "If you don't like it here, go somewhere else," knowing full well they can't.

Mr Wessenger: I don't want to suggest to you, but it would seem that if you have problem of recurring violations, you need a more flexible inspection process. Is that what you think you need, to pay more attention to these facilities that are clearly having repeat situations?

1140

Mrs Hannah: Right.

Mr Wessenger: Fine. Thank you.

The Chair: Thank you very much on behalf of the committee for coming here today. We appreciate your brief and also the answers to our questions.

CONSUMER COALITION ON LONG-TERM CARE

The Chair: If I could call our next presenter, the Consumer Coalition on Long-Term Care and disability issues. If the representatives would be good enough to come forward and, as they do, if I could just note to committee members that Miss Caplan has talked to the Chair and also to some of the members on the committee to permit one final person to come briefly before the committee at 12 o'clock or when we finish this particular group. This concerns the case we've been discussing that she raised both in London and yesterday in Sudbury. So there would be one final presenter, but that will be following this one.

First of all, let me thank you both for coming before the committee today. We have your submission and other attached documents that are being circulated. If you would just be good enough to introduce yourselves for the committee members and for Hansard and then please go ahead with your submission. Ms Patti Bregman: I'm Patti Bregman, and I have been the consultant working with the coalition. I'm working as a lawyer at the Advocacy Resource Centre for the Handicapped, working on long-term care and other issues. For the record, I should say that I have also been a long-time user of long-term care services. I've been doing home IV therapy for seven years now. I'm probably one of the people who has saved over 180 days a year in a hospital as a result. So I do have a very personal interest.

The Chair: We should issue you a cheque at the end of the presentation.

Ms Bregman: That's right; seven years.

Mr Sam Savona: I want to thank you for having us. My name is Sam Savona. I'm the coordinator of the Consumer Coalition on Long-Term Care. I myself live in an SSLU. I've been living there for about 16 years, and in particular in this one, the tenants have seen a revolution, from not having a representative on the board of directors to having a majority on the board of directors. I may add one more point, that I am presently the president of that board.

Ms Bregman: There's one more thing that Sam had asked me to indicate earlier, that if anybody has trouble understanding him, if you'd just indicate it, I can interpret back for you. I think most of the comments are written, but we may diverge from that.

The Chair: Thank you.

Ms Bregman: Basically, knowing that Concerned Friends was ahead of us and would do such a wonderful job of making presentations on the issues with respect to seniors and the residents and nursing homes, we're going to address Bill 101 and put it into a context for you because, despite what the parliamentary assistant said before about legislation that may be forthcoming, we have a great number of very serious concerns about Bill 101 going forward as it stands now without any other legislation that's going to protect us in the community and with respect to housing.

In particular, we're going to link this to Ernie Lightman's report on unregulated accommodation, because both at ARCH and PUSH in the last six months we have seen an unprecedented increase in the number of calls from individuals, living in support living units, living at home and living in institutions, who are having services cut, threats of service cuts or threats of eviction.

Basically, what has happened is that we have developed a very large system of unregulated care outside of the regulated sector. What concerns us in the context of Bill 101 is that we will see a nice process for getting into certain long-term care facilities but absolutely no indication of protection for the people who are currently living in substandard conditions.

We've got Professor Lightman's report. I urge you, if you have not already heard from him, to ask him to come before the committee to discuss some of his findings. This month alone in Windsor there have been two inquests coming out of unregulated housing. There have been fraud charges against a chain owner of one of the largest unregulated housing operators. As you can see from the two situ-

ations which we've attached to this brief, there have been problems in Windsor with somebody receiving attendant care services, and we are currently working with the Peterborough legal clinic on behalf of the residents of Peterborough who are threatened with eviction on Monday. I should tell you that we have made it known to the landlords that we will fight this and that we will challenge the exemption under the Landlord and Tenant Act.

However, we consider it within your mandate and within the scope of Bill 101 that in order to address long-term care and even residential care, movement has to go towards doing two fundamental things: one is to separate housing and services, because currently there is that linkage, and I'll talk about it a little at the end; second is to make sure that people living in this accommodation have the same rights any other tenants in the community have, because without this, we will see a fight for the perfect resident. I think we saw some of that a bit this morning and with good reason. Residents want to think that they're going to live with other people who are like them; they don't want to live with people who may have a psychiatric disorder or somebody with a psychogeriatric problem or who has HIV or AIDS.

What we're finding is that, as it becomes more profitable and acceptable to exclude categories, we're going to be left with, as we see in Peterborough, this group of people nobody wants. Unless we build along with this legislation some kind of protection that's going to make sure those people don't get constantly shifted from place to place, we're really concerned about the safety that they are going to face. Believe me, if they go through with the eviction in Peterborough—we've heard it said by people in the community that the owners have tried to get one of the people recommitted to Kingston psychiatric facility. They want to put them in hostels that are used for men coming out of Kingston Pen. This can't be allowed to continue.

We have a great deal of concern that the message this legislation sends is that there is only one category of residents worth protecting and that with the Lightman report being ignored, it's sending the wrong message and leaving these people unprotected. I will get back to that, but I did want to turn it over to Sam to talk about the direct funding, which is the other critical issue for this community.

The Chair: Just before Sam begins, if there are any difficult parts of his presentation, I'll just stop perhaps and ask if you could help the committee.

Ms Bregman: Sure.

The Chair: Thank you. Please go ahead.

Mr Savona: My name is Sam Savona. Direct funding must apply to a broad range of services, including, but not limited to, attendant care services. As I am sure you are aware, direct funding of services has long been a goal of people with disabilities, particularly those with mobility impairments who currently rely on attendant care, myself included. Although some people with disabilities are currently receiving care through orders in council, most people with disabilities are currently restricted to services available through service agencies, which are limited in availability and restricted in the scope of services.

We were pleased to see that direct funding was included in Bill 101 and that it was not restricted to attendant care services. This is important since there are many people currently receiving services not strictly defined as attendant care who would benefit from the ability to hire and train their own providers or at least have some control over the process. However, as it stands, this amendment is permissive only: There are no guidelines or indications as to who will receive direct funding and in what circumstances. I'm having a hard time.

1150

Expanded access to direct funding for long-term care services: We believe that the reason for the amendment is to allow for the funding of a pilot project. In our opinion, the time has come for the development of a more comprehensive program of direct funding. We already have years of experience on direct funding of attendant care through those people now funded through orders in council. In addition, the Workers' Compensation Board has used direct funding for several years, and there was recently a committee established under the auto insurance reform to look into direct funding.

We need to move swiftly to develop a fair, comprehensive program that will expand the range of services available and increase the number of people eligible to receive direct funding. This is critical if we are to respond to the increasing number of calls that we are receiving at PUSH and that ARCH is receiving from people who are having services cut amid allegations that they do not get along with the people the service provider wants to send or who cannot get the appropriate services because there are program restrictions.

Ms Bregman: I'm going to pick up here because we're talking a bit about the case that came out of Windsor, which is not the only case that we've heard about, and this is women with children. Women with disabilities can and do have children, and they're encouraged to do so, yet they turn around and find out that attendant care services will not assist children regardless of whether or not they're assisting the parent. In this case, they refused to cook dinner for the children. We're not talking about babysitting or child care; we're simply talking about serving the two children when you're cooking dinner.

In this case, the mother, for nine months, was afraid to complain to the agency because she knew if she complained she'd get nothing. The children were forced to kiss the picture of the attendant's cat in order to get fed. This went on, she complained about it and they said, "No, you're neurotic." She complained again and finally she started a branch of PUSH Windsor, after attending our long-term care conference this September. Then they said, "We're cutting you back because nobody wants to go and see you any more," which was blatantly not true.

We're pleased to say that the Ministry of Community and Social Services has stepped in and to date there's been no service cut. But she's not alone. We've had several calls at ARCH from women who have been threatened with a loss and in one case have lost custody of their children. That's not acceptable. Yet we see, because we're not deal-

ing with the community—we've got these service providers thinking they can do what they want—we don't have any protection. We're going to see more and more of this grow as people move outside that restricted sector.

I want to go back to the housing and residential issue, because I think it's important to understand what's going on here. Under the Landlord and Tenant Act, it exempts places that provide housing for care or therapy. This was done a long time ago. We are challenging this as being contrary to the charter. However, until that happens, this still exists and many operators still assume that's how they will operate. We now have 993 people living in support service living units who are not entitled to the same protection you and I are, including Sam, who is obviously quite competent to make decisions, but simply because he's forced to live in a place, because he needs service, he doesn't get it.

I think we need to think about this in the context of Bill 101. We would like to see the bill expanded to make it very clear that the service separation applies across the board and that housing becomes regulated.

Mr Savona: If I-

The Chair: Sorry, just before you go on, Sam, we're going to go through the whole brief. I know there are going to be some questions.

Ms Bregman: Yes. I actually wasn't going to go through the rest of it in its entirety. I just thought I would briefly outline.

The Chair: Yes, that's fine. I appreciate that.

Mr Savona: If I may make a point here, as Patti said just now, I am a receiver. To give you one example of what is happening out there, last year I went through an ordeal myself. I wasn't able to have my bath for weeks. After eight years my attendant decided that the way they were lifting me in and out of the bath wasn't safe. This was after eight years, without talking it over with me to see if there was another way or to get my own opinion. They decided arbitrarily that they were not going to lift me in and out of the tub.

Ms Bregman: It's this kind of constant "we own you" attitude. In other words, in most places, if you decide you don't like what the attendant is doing—in Sam's case, it was suddenly, "Gee, you can't have a bath any more because I can't lift you"—you don't have any options. You have absolutely no protection against complaints right now. I should say that Sam is now heading up a new tenants' rights advocacy project that PUSH is sponsoring.

One of the biggest problems we're facing in organizing is getting members who are willing to speak out publicly, because they know they're subject to harassment. Here are people who can't do anything physically. We have people who have been left in a wheelchair overnight because they complained. I think as one of the excerpts from releases that I distributed shows, just talking about the fact that there's a problem in your home is grounds for eviction.

The situations that we see going on on a day-to-day basis and that we get calls about are scary. One of the scary ones—it goes back to what somebody was saying this morning—is this question of people who deteriorate. Currently, what happens is there's no protection so they get shoved out. We've had calls from people who've got multiple sclerosis or, in one case, Friedreich's ataxia. Suddenly, while you can't be in an attendant care facility because you have to be self-directed, it doesn't matter that we could bring somebody in for you, we will not let you stay.

Until we get some kind of protection and some kind of recognition that if we're really going to have community living, it's in the community and not what is going on now, which is subsidized institutional living but without the protection of the institutional legislation. Somehow or other, in the very near future—we can't wait for the next piece of legislation—we have to deal with it, and I think Bill 101 is a place in which it can be dealt with.

I will stop there. I think the rest of it's self-explanatory.

The Chair: I know there are a number of questions. We really do appreciate the documents you have brought, but if we could then move to questions, and we'll begin with Ms O'Neill.

Mrs O'Neill: Thank you very much for coming. I think if I remember correctly, you are the first ones who have asked us to have Dr Lightman come before us. That certainly is an idea I think we should consider.

Ms Bregman: I should tell you that he would be willing to appear if asked.

Mrs O'Neill: Certainly, I am having a lot of correspondence on the report, but I agree with you that there has been no reaction from this government on it. It's very helpful, Sam, that you would bring even that very last personal story to us. We did meet with the lady you mentioned from Windsor. You likely know that. I think that too was a very helpful presentation.

I think there have been infractions or should I say deep misunderstandings. It's hard to use words stronger than that in committee on the attendant care situation. Can you tell us a little bit about how you feel about attendant care workers and the training they receive? You are part of the group, I understand, who are working on training, both those who receive the care and those who give the care, which presented in one community. I thought it was a good idea. Do you want to say a little bit about how you think the attendant care could either be attended to in Bill 101 or improved in the regulations that would accompany it?

Mr Savona: As consumers, we are always dealing with this issue. We've been hearing that attendant care workers might be regulated or might get a certificate or grading. Our backs go up when we hear the words about the certificate or licences, because attendant care work is very, very personal. Not everyone wants their cup of coffee the same way as the rest of the others. By the way, when I hear that people might be licensed or might be certified, I'm wondering, are they going to take away my individual way of living. Even though I'd be demanding someone come into my own home, and I ask them, "Please give me a shave with an electric razor," and they go: "Oh, I wasn't trained to use an electric razor. I was trained to

use a straight razor, and that's the way you're going to get your shaved."

Ms Bregman: We do recognize that there are going to be cases in which people cannot train their own attendants, may not choose to train their own attendants, may need some assistance. We have no objection to having programs around. I'm sure you heard from people from HAGI when you were in Thunder Bay, which is the consumer-run attendant care service provider. That's great. We think there need to be multiple options available. We don't believe in shutting it out, but I think as Sam said, we have a great deal of difficulty with a specific certificate required. It's great to have training available, it's great to have courses, but I would not necessarily want to see that in regulation.

There is some need to deal with some issues of quality assurance, particularly in the area of abuse, and I think we do have to work through how to deal with that, but that's a separate issue.

Mr Savona: Let me add one more thing to Patti's statement. We do agree that there should be some kind of basic training, but I would emphasize this point: I feel my colleagues would agree that whatever training program is developed, the consumer be in on the very first step, at the very beginning, improving and also administrating every aspect of the training.

Mrs O'Neill: You did indicate in your presentation, Sam, your very first intervention. You said you're concerned about who will receive direct funding and in what circumstances; the uncertainty that surrounds that area. Could you say what your concerns are or what are the uncertainties that hang over Bill 101 in your mind in this area?

Ms Bregman: Maybe I'll respond, because I've been doing some of the analysis. We just don't see any guidelines, to be honest. What we want to make sure is that it's not limited simply to a pilot project that goes out there, which we've been hearing about for a long time. We want to make sure that direct funding can be made available for people who need a variety of services. We think a number of people can be independent in hiring, and it will assist particularly women with children, for example.

We just think we should have more of a move towards a direct funding system that will allow flexibility in what people need. We've been running into some problems in the multicultural community, to be honest, with people in attendant care projects or whatever who are told, "The attendant doesn't like East Indian cooking," for example. So I think the more we have direct funding, the more flexibility. We just want to make sure that it's broad and it's not simply restricted to attendant care services.

Mrs Marland: Speaking again as the person for the PC caucus who represents disability issues, I want to thank you both very much for your presentation this morning. It's been a concern of our party that there are so many things wrong with this bill obviously, but in the area that you've particularly presented this morning, I think you're here emphasizing all the concerns that we've had.

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Mind you, I have to admit that as far as attendant care, I've had the disability portfolio now for almost eight years and for that length of time I've been asking questions on attendant care in the House and certainly ARCH and PUSH are well aware of what I've been doing in that area. But, you know, it's shameful really that anybody has to come and ask for something that's so obvious. I think that's the bottom line. This is my last opportunity to sub on this committee, so I might as well hit right out.

What I think has disappointed me most about this particular government is when it was in opposition, it was the party in this province that had the licence for compassion, caring and support. They were the only people, if you listened to them, who ever cared about people with disabilities.

I've got a file of letters here, by the way, and I brought them in this morning because again the committee members have heard me talk about Kathy Harvey who is president of the residents' council at Mississauga Hospital, who is a multiple sclerosis patient since she was 34 and she's about 47 now. Kathy came up with a wonderful idea, which I'm sure, Sam, you would be interested in.

It's an idea where people with disabilities at all levels, never mind people who need an attendant but also people who needs nurses, could have a system across this country which she, for lack of a better name, called bed swapping, but really it's sort of home swapping. It's residence swapping, and if your residence happens to be an apartment or your residence happens to be a hospital bed, that it would be possible to organize this across Canada so these people could travel, meet other people in every corner of this country.

Do you know what's really ironic is, I wrote to the ministers, both Community and Social Services and Health, to put forward Kathy Harvey's proposal and every single province in Canada has responded to this proposal with great support, with great enthusiasm, I have yet to have a reply from any of the ministers in this province about this idea.

So I hold little hope for anything to be changed to address the concerns that you're speaking to this morning, at least to be addressed in the next two years with this current government because unfortunately this government uses people very badly. I think the fact that they won't even pick up on an idea where people can travel and have experience in other parts of this country and perhaps teach people in other provinces what we might be doing better in Ontario or maybe learn something in Yukon or British Columbia that we could do better in Ontario.

The scope of this one program is limitless. It's so exciting and I'm so enthusiastic about it and I don't even get a reply. I think it would be wonderful to have Professor Lightman before this committee. I'm just sorry that I won't be a member of the committee to be part of hearing him or making amendments to the legislation to address recommendations that he might make or to address the recommendations that you have made. But we will certainly convey your recommendations from this morning to those members of our caucus who will be going through

this bill clause-by-clause, and I thank you very much again for the tremendous presentation that you've made today.

The Chair: Thank you. Ms Carter.

Ms Carter: Thank you very much and I want to welcome you, especially as the member for Peterborough. Certainly your presentation has filled a gap. We've had far more presentations that were to do with specific seniors' homes and so on. Of course, this reminds us, I think, of the kind of situation that led to the Advocacy Act, for example, where there was the home in Orillia where somebody died, Cedar Glen, because there was really nobody he could appeal to who could rescue him or the other people in the home.

Of course, in Peterborough we have a particular situation that has arisen—you have given us documentation on that—where a privately owned home, basically for seniors, which has recently changed hands, issued eviction notices to 13 residents who were people, I think, aged on average about 40, several of them are ex-psychiatric patients, I think they are schizophrenics, but who really, one would think, would need a different kind of institution and a different kind of care to what they were getting in that institution.

It's not good for younger people really to be in the same institution as the very much older people. They have different needs. But of course their immediate problem is that they're no longer even going to be able to live there, so that naturally, the Ontario Friends of Schizophrenics and other groups in Peterborough are very anxious to remedy this situation. They have been to my office and taken a rather hostile attitude that I didn't feel was justified because myself and my staff were very willing to work with them to find solutions, but of course the point is the solutions aren't there. It was suggested that some of them go to a mission, which is mentioned here, which is really for men who are on the street and homeless and is not intended to be a long-term home for anybody.

So what I'm suggesting is that we do in fact have gaps in our view of what is needed. We need to look at that as a government in our legislation. I wondered if you would have any suggestions as to what kind of things we need here.

Ms Bregman: I think ultimately what we need is more development of community support programs that would ultimately enable these people to live in their homes, and to develop the community mental health services. But I think we also need the protection from eviction, even if it's not the most appropriate place. The problem is there isn't any alternative. This is, in a sense, where we find ourselves.

We certainly need more and an increased number of outreach services as well as housing, basically, housing development. But again, it's only going to work in terms of providing more housing and all of that if we provide protected housing; in other words, housing that not only has services that can be brought in if necessary, but basically housing like everybody else's and that has the same rights as everybody else has attached, and that we deal with the service needs and we deal with the other problems in the same way anybody else does. That is by bringing in

community-based services. That will give us an incredible amount of flexibility. We wouldn't run into this situation, necessarily. These people could then be moved into private, normal apartments and the supports be made available in those apartments if they were community-based.

Ms Carter: So that the landlord is a landlord in the same sense as for anybody else.

Ms Bregman: That's right.

Ms Carter: Of course, we do tend to forget, people don't have basic rights very often when they're in this kind of situation.

Ms Bregman: What happens and what we've seen and the roomers' and boarders' coalition has seen is that landlords, including the for-profits—in this case it's fairly clear there's a profit motive—introduce minimal services and they get exempted from the act. That, we think, is a very serious problem and we're seeing it growing. The courts have decided that absolutely minimal service gives you that exemption. So there is now a phenomenal incentive, particularly with the number of nursing homes beds frozen, I think, as Freda Hannah said, we'll see more people going into unregulated housing to develop this because they can make a lot of money.

We think that it's absolutely imperative that this housing be viewed as just that, that we no longer evict people only because the services aren't the ones that person happens to want or need. What we have right now are institutions in the community, to all intents and purposes, where people have no control over where they go or how they go.

The Chair: Thank you very much. I'm afraid our time has come to an end, but Ms Bregman, Mr Savona, we want to thank you for the presentation, for again the documentation and I think in particular the personal examples and stories. You've brought a dimension that we haven't received every day during our hearings. So we have you again for being with us this morning.

Mr Savona: You're welcome. Thank you, every one of you, for taking the time to listen.

Ms Bregman: I'm sure you'll hear from us again.

The Chair: Thank you. Good.

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SANDY SPRING

The Chair: I'm now going to ask if Miss Caplan would bring Mrs Spring to the table. Perhaps, Miss Caplan, you could just give us the context again. I would just say to members that we'll be fairly expeditious in going through this, as I know we have to get organized to get a flight to Ottawa.

Mrs Caplan: Thank you very much, Mr Chair. I'd like to introduce Mrs Spring. She's a little nervous to be here this morning but is happy to answer your questions.

You've heard the story without the name of the individual in both London and in Sudbury. We've also heard a lot at this committee about choice and flexibility. We've heard that this new long-term care system is supposed to result in a greater sensitivity to the level of care that the individual needs and to the service requirements. In fact,

we heard the last presenter make the statement that a person shouldn't be forced to live in a place just because he needs the services, and in fact this is somewhat similar.

Dr Spring, Mrs Spring's husband, right now is in a chronic care hospital here in Toronto. He's been in two chronic care hospitals, and both are requiring that he sleep in the institution in order to receive the speech therapy that he requires. Mrs Spring is requesting the minister and the ministry to tell the hospital that it's okay for him to receive the service but be allowed to sleep at home and spend the evening at home, because in the environment in the hospital he's not sleeping as well, with other patients in that particular unit tending to cry out and so forth. It does interfere with his sleep.

So it's really a question of telling the hospital that it won't be penalized in any way if it's flexible enough to allow him the choice to spend his evenings and sleep at home. I put it a slightly different way. We've talked about the name on the bed not being as important as the person who needs the service. So my suggestion has been to let them leave his name on the bed and then allow him and his family to have the flexibility to see that he comes in for his intensive speech therapy, which is only available in Metropolitan Toronto at this time as part of an inpatient program.

Mrs Sandy Spring: That's about it. That summarizes it very well.

The Chair: Would you like to make a few comments?

Mrs Spring: I did write something out. It's sort of an emotional piece. Are you—

The Chair: Please go ahead.

Mrs Spring: All right.

The Chair: If you wouldn't mind just approaching the microphone just so that we can pick up what you're saying. Thank you.

Mrs Spring: My husband, Dr Morris Spring, was a practising physician in general practice up until—

Mrs Caplan: It's okay. You don't have to.

The Chair: Take your time.

Mrs Spring: I want to—until Tuesday, December 15, 1992. He was on staff at Northwestern General Hospital and a past president of the medical staff. Wednesday, December 16, the day after, 12:15 am, my nightmare began. I woke up to find my husband incoherent, and I knew immediately he was having a stroke. I telephoned my nephew Jeff and he answered. He arrived 10 minutes later and drove us to Sunnybrook hospital. I can't tell you how frightened I was. Terror gripped my very soul. I could not eat or sleep for the next two weeks.

Seeing my husband in a stroke unit with an IV running, a catheter, plus his inability to speak, was extremely devastating. Dr Johnson, the attendant resident physician, told me that first night to be prepared for more possible progress of the stroke and the uncertainty of the prognosis for the next few days, as there was weakness in the right side.

A few days later, Saturday, December 19, the IV was discontinued, catheter removed, and he was sitting in a chair at short intervals. The following day I arrived to find my husband out of bed, walking up and down the corridor.

He was able to answer questions with a yes or no. Although his speech was absent, he appeared to comprehend his predicament and was determined to get better.

My sister who lives in Milwaukee, Wisconsin, left a busy law practice to be with me for the next two weeks. She's a tremendous help emotionally to me.

On December 24, he came home on leave from Sunnybrook hospital. It was wonderful having him. He swam 50 lengths in our indoor pool—I live in a condo—and helped with all the household chores and cooking. His spirits were good. His being home seemed to normalize our lives and did a world of good for all of us.

He returned to the hospital a few days later, but it was a total waste of time. It was the holidays, and there were no therapy or programs available, as his physicians were on holidays. He was discharged December 31.

Two weeks later, Morris saw Dr Somerville at Sunnybrook, who follows patients who have had strokes. She strongly recommended he be admitted to Riverdale Hospital so he could get daily speech therapy and some physio. She said it was imperative that he have intensive speech therapy daily and anything else would shortchange him and affect his future. He spent three weeks there with weekends at home. There was progress with his speech.

On February 10, we transferred Morris to Baycrest under the care of Dr Morris Freedman, a neurologist, as I thought it would be easier for me to go back and forth. The same rules apply at Baycrest: The patient has to stay in hospital with weekends at home.

Conclusion: To keep Dr Spring in hospital for a couple of hours of therapy is not beneficial to his emotional and physical health.

I'm here to have you change the rules and allow a patient who requires therapy in a hospital to be allowed to have it as an outpatient, contrary to the present rules which insist you stay in the hospital.

That's my story, and it's a happy ending because the prognosis is very good. His speech in the last two weeks seems to be spontaneous. He is speaking more, and he's as intelligent as he was before the stroke. I'm just nervous talking in front of you and thinking about what happened. Going back a bit, it is very disturbing, but the prognosis is very good. When he's at home, our life is just fantastic; it seems almost normal because he understands everything I say. I work with him on his language. I'm just on a cloud right now, although it doesn't look like it, but I am. I'm very happy right now. Thank you for listening to me.

The Chair: Thank you very much, and I'm going to just allow a question or comment from each caucus, but I want to thank you. I know that it has not been easy to come before the committee, but we thank you for doing it and for telling us about what you have been going through, because the intent of all of this, that we all share, is to make the system a better, more responsive system.

Mrs Marland: I can't thank you enough, Mrs Spring, for coming before the committee, because you've told me something that I didn't know existed. I realize it's very difficult for you to come and that this is a very foreign

atmosphere. We try to be human, and indeed, speaking for all the committee members, we are.

I just want you to know that, first of all, we're very sympathetic to what you have been through. That indeed has been a tremendous trial, but I cannot believe that there is a requirement to hold a bed during the week in order for your husband to receive this treatment. I thought the direction from the Ministry of Health was the opposite. I thought they were now doing everything on an outpatient basis

If Dr Spring is able to be home on the weekend, they obviously don't think that he's in any kind of risk being out of the hospital environment, so the absolute absurdity is that he has to stay in that bed Monday to Friday in order to receive his speech therapy and physio. As you say, it's now at Baycrest, so you've had the same policy at two hospitals. I think that you're here as a very strong ambassador today, pointing out the absurdity for all similar patients in this province who live through this.

1230

Actually, through the parliamentary assistant, I would say to the minister that I hope we can get this remedied immediately. I thought there was a shortage of beds, for crying out loud, and here we have a situation where someone obviously doesn't need a bed, according to his own attending physicians, and doesn't even need the bed on the weekend, according to the hospital's responsibility. So I look to some kind of commitment from Mr Wessenger that the remedy will be forthcoming, it will be addressed and that this bed can be used for someone else in long-term care who doesn't have the option of being at home on the weekend and yet, as in Dr Spring's case, can have the treatment that he obviously needs at this time.

So surely to goodness we can get that kind of commitment, and I think that if there were any days that Dr Spring had to be in hospital, maybe if they extended his treatment one day and he had to be in that particular night, there would be flexibility in a facility the size of the two that he's been in that this eventuality could be addressed if it was a one-night situation from time to time, working in the availability of that bed for respite care for other families that need it from time to time. We're told all the time by the ministry about the cost of one bed in a hospital for one patient, and here is a situation where it's being mandated. It's so backwards it's unbelievable. So I do thank you very much.

The Chair: Thank you. Ms O'Neill?

Mrs Marland: Excuse me, can I get that answer from him?

The Chair: Mr Wessenger will be speaking. I'll just get a few comments from Ms O'Neill.

Mrs O'Neill: This case, as you know, was brought to our committee yesterday, and I heard an explanation from the ministry official who is now walking away. I wonder if he would say what he said in Sudbury yesterday so that we would have some verification that this was the end of the line for this incongruity. Maybe Mr Wessenger will begin and ministry officials will continue.

The Chair: I believe they're going to respond.

Mrs O'Neill: Okay, because I thought yesterday we had some assurance, and I'd like to have that repeated because, as I understand it, some of the assurances were made in conversations after Hansard.

The Chair: I will ask Mr Wessenger to respond, and I just note for the record that this was raised in London as well as in Sudbury.

Mrs Marland: I wasn't in London.

The Chair: No, but I'm just saying it. I'd like to ask Mr Wessenger if he would respond.

Mr Wessenger: Thank you very much for coming here, Mrs Spring. I really appreciate your difficulty and the difficulty of your husband in dealing with these rigidities. First of all, I'd like to assure you there is no government regulation whatsoever which prevents Baycrest from providing outpatient speech therapy. It really is a question of the policy of that particular institution. What I can assure you is that we will certainly do everything we can to try to see that the policy is changed; that's the assurance I'd like to give you.

Mrs Caplan: That's a very specific request, and I've spoken with authorities at the hospital. What they say is that the level of speech therapy that Dr Spring requires is only available as an inpatient service. So there's that issue. The issue really is whether or not they will permit him to spend the evening and stay at home whenever he can or would like. The issue for the hospital is not so much shifting its service from inpatient to outpatient, but it's the flexibility of allowing a designated inpatient to not only have a weekend pass but to also be able to spend whatever other evenings and nights at home that he is able to. It's that policy that I believe they're concerned about. They say that there's a regulation, a requirement for a head count, and that in order to be classified and have an inpatient service available, you must sleep in the bed.

If the minister and the ministry would tell them that they could make this exception and allow an inpatient to sleep at home during the week, just as they allow him to sleep at home on the weekend, that flexibility would give him the choice, and I think it would be a benefit to his wife also. Obviously, what you've heard from her is that they're happier with that.

So it's not just changing your program, it's allowing the flexibility within your existing program for somebody you're letting sleep at home on the weekends to do the same thing during the week if he wants to. I said to put a teddy bear in the bed if you need a head count or get a volunteer to lie down on the bed when you're doing your head count at night; be sensible about this. But they said

there's some regulation that says if you're registered as an inpatient, you have to sleep there.

The Chair: It seems to me that the case has now been clearly presented. The committee is going to be sitting for a number of weeks yet. I think we have the commitment from the parliamentary assistant to take this issue back and to look into it so that we will try to get a response.

Mrs Caplan: Perhaps the government could change the policy that would be specific in permitting that for inpatient services. That would be helpful.

Mrs Marland: I don't feel that I have a commitment from Mr Wessenger. I've heard him say that they would look into the policy at Baycrest, but what I would like for the taxpayers of this province is a commitment that where this option exists, there is a mandated requirement from the ministry, which funds these hospital beds through the taxpayers of this province. Obviously, in the long run Dr Spring is going to require less physio and less speech therapy because he is able to be at home with his wife and family. So in the long run it's going to cost less money for that individual patient, but also there's the option of using the bed for somebody else who needs it.

So I think what Mrs Spring has brought to the committee today is not only her husband's example but an example that obviously must exist across the province. I want to hear Mr Wessenger say that he will speak to the minister about a remedy so that we don't have to subject Mrs Spring to coming back a year from now and telling us that this ridiculous, nonsensical bureaucratic situation still exists.

Mr Wessenger: The only thing I can add to what I've said is that I certainly agree there's too much inflexibility in the system, and obviously what you have to look at is making the system more flexible. That's really what we want to look at, making it more flexible and also enabling us to deal specifically with the problem Mrs Spring has. We want to deal with her problem, but we also want to deal with the whole problem of the flexibility of the system.

Mrs Marland: Never mind looking at flexibility. Will you work for a remedy?

The Chair: I believe the parliamentary assistant has indicated that he will do so. Mrs Spring, again, I want to thank you for coming before the committee, and I know, through Mrs Caplan and through the ministry, that you will be kept abreast of what is happening. But again, thank you. I know it wasn't easy, and we appreciate it.

I just note that the plane leaves at 3 o'clock, and I trust that everybody can get there on time. We stand adjourned until we meet again tonight in Ottawa at the Westin Hotel.

The committee recessed at 1240.

EVENING SITTING

The committee resumed at 1840 in the Westin Hotel, Ottawa

The Chair: Good evening, ladies and gentlemen, and welcome to the first of our hearings in Ottawa. We're going to be here tonight, tomorrow morning, tomorrow afternoon and tomorrow evening to hear presentations on Bill 101, An Act to amend certain Acts concerning Long Term Care.

I would like at the outset just to inform committee members that we have heard back from the House leaders and we have been given permission to meet after the break for two days on clause-by-clause. So the week of March 8 will be hearings, and that will provide us with an opportunity to ensure that everyone is heard. I think that's good news.

J'aimerais aussi dire que nous sommes très contents d'être ici comme comité. Nous aurons trois séances à Ottawa, ce soir et demain, et on va discuter du projet de loi 101 qui touche la question des soins à long terme.

RIDEAU REGIONAL CENTRE ASSOCIATION

The Chair: With that, we'll invite our first presenters of the evening, from the Rideau Regional Centre Association, if you would be good enough to come forward. Help yourself to some water. If there's anything you'd like distributed, the clerk can pass it out.

Ms Molly Morris: I believe that has been done.

The Chair: Okay, fine. I want to welcome you both to the committee. You don't need to touch the mike. We always have to remind ourselves that if you touch them, we all sort of self-destruct, and we would hate to see you disappear. But if you'd be good enough just to identify yourself for the members of the committee but also for Hansard, then please go ahead with your presentation.

Ms Morris: My name is Molly Morris and I'm a member of the Rideau Regional Centre Association.

Mrs Eleanor Bradley: And I'm Eleanor Bradley. I'm the secretary for the Rideau Regional Centre Association.

Ms Morris: Good evening. I'm a member of the executive of the Rideau Regional Centre Association. The Rideau Regional Centre Association is one of the eight member associations of the Federation of Ontario Facility Liaison Groups, parents, relatives and friends of developmentally disabled people who live in Ontario institutions. The federation was formed 12 years ago when it became apparent that the needs of adults who had profound disabilities and who lived in facilities were neither understood nor realistically addressed by the proponents of the policy to close institutions and to use only generic community services.

When I was invited to speak before this committee, I felt I had a lot in common with Hillary Clinton:

(1) It's my relationship that makes me an important person. No, he's not the President, he's a resident of the Rideau Regional Centre;

- (2) I've not withstood election to hold my position. I feel, though, that as a member of this advocate group, I represent the 780 residents of the schedule 1 facility and the 583 relatives and friends who are currently members of this association:
- (3) I have accepted an assignment that, no matter what the outcome, is bound for criticism; and, finally,
 - (4) This job has no remuneration.

I appreciate the opportunity to appear before this standing committee. Consultations on the redirection of long-term care and support services and the proposed Bill 101 are directed towards elderly people and those with physical disabilities. However, there's a significant population of adults who are developmentally disabled who require care and services throughout their lives. Many have physical disabilities, mental disorders and, in the cases of adults in institutions, a growing number fall under the category or definition of being elderly. It is on the behalf of these people that I wish to make the representation tonight and to make certain that the special needs of the mentally retarded are included in plans for long-term care in Ontario.

My association with developmental disabilities began the day of my birth. Instead of watching the Victoria Day fireworks, my mother was delivered of me by forceps. As did every good father in the early 1950s, the local vet continued on and delivered a mare of her foal. Also that day my uncle, a physician practising in rural Saskatchewan, set out on a three-day journey by car to the Ottawa Civic Hospital. My mother was overjoyed to see her brother. Then she was shocked and then dismayed. Why was he so concerned about my Oriental features? Two years earlier, he knew of my brother's prognosis. Until my birth, it was beyond his professional ability to share his concerns with my parents. Neither his training nor his expertise has equipped him to share the sadness of his knowledge.

I enjoyed the tender, nurturing environment of a small eastern Ontario village. It was a warm, accepting community. At three, I knew I belonged. When Mrs Evans saw my brother Mark pulling his little red wagon filled with me and our dog, Cocoa, she shared her uncooked sugar cookie dough. Mark also knew that Mr Brown's bakery was the best source of chocolate doughnuts.

At five, I realized that Mark was different. While walking home from kindergarten on the path through the hay-field, Peter, my friend, told me that his mother would no longer allow me to play with him.

After being expelled from grade 1, Mark went to live at the Rideau Regional Hospital School in Smiths Falls 32 years ago. I can only imagine the anguish my parents experienced at this time. Yet, supported by the recommendations of the most qualified experts in the field and worn thin by the demands of four young children, a mentally retarded son and their independent professional practice, my parents agreed to Mark's admission.

My dad, alone, took Mark on the half-hour drive on the day of his admission. Walking hand in hand down the

long, busy corridor at Rideau Regional, Mark increased his grip. Neither dad nor Mark had ever seen such a variety of humanity. Dad, betrayed by his tears, increased his grip. Sharing their terror, Mark turned to my dad and said, "Daddy, they're not going to make me blind in here, are they?" My dad did not enter the doors of that institution for 20 years.

I still have my adolescent journals referring to the atrocities that we saw Mark live through. Yes, I understand what Peter Gzowski's guest referred to last year when he talked of such institutions as fruit bowls. Vegetables are closely related to fruits, aren't they?

Fortunately, some years ago, someone saw fit to look at Mark's home as his home. They discovered that the vegetables belonged in the fridge and the fruit bowls could be used for potato chips during hockey games. Mark and his special needs were addressed and served. He was recognized as a human being with intrinsic value in his humanity. His special medical, dental, physical, exercise and nutritional needs were served by interested professionals with expertise in mental retardation and for the most part committed to a long-term relationship. His psychiatric, psychological, vocational, educational, recreational and spiritual needs have been similarly met.

Yes, finally, Mark is at home. This is his home. He shares his swings with my children and never misses a chance to sit down with me for a coffee. He's proud of his bed, his cow in his cupboard, his coffee break from his job, his friend Doug and the rest of the guys and his long-time friends and care givers. It is in this community that Mark is safe and secure and comfortable. It is in this community that Mark is happy and contributing. This is Mark's community.

I've read this part of my submission because I have chosen these words carefully and deliberately. As the sister of a developmentally disabled person and as the mother of a developmentally delayed daughter, I have strong emotional reactions to issues related to long-term care in Ontario. As a sibling and as a parent, I believe I hold a valid, unenviable perspective.

All of the Rideau Regional residents are adults ranging in age from 28 to 75; 85% of the population are over 30 and 45% are over the age of 40. All 780 residents are mentally retarded; 90% are diagnosed in the severe to profound range of retardation. About 80% have been dually diagnosed, that is, they have other problems as well as being mentally retarded, such as epilepsy, blindness, cerebral palsy or deafness: 46% have epilepsy, 6% are profoundly deaf, 16% have cerebral palsy, 33% exhibit severe behavioural problems and 19% are non-ambulatory.

It is the present policy of the Ontario government to close residences such as the Rideau Regional Centre and discharge the residents into the community. There are not the services in the community to serve these people even in the short term, let alone the long term.

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Two years ago, when I first sat on the executive of the Rideau Regional Centre Association, I brought with me my baggage of sibling, parent and qualified educator and social scientist. When faced with the long-standing long-

term plans of the Ontario government to close residences such as Rideau Regional, and faced with the concerns of aging parents, families and friends, I began my quest for empirical data to substantiate such discharges and closures. Such data and analysis are not available.

Had any such long-term experiment been conducted on the mentally retarded without consent, scientific tracking and analysis of impact in either the medical or pharmaceutical fields, charges of abuse would have been laid and at the very least the experiment would have been quickly halted.

In a recent CBC radio series on facilities and services for the mentally retarded in the Ottawa area, one frustrated father of a young man no longer served by the Ministry of Education stated that he recently learned that, as a parent, you never eliminate any option.

I request that the process of deinstitutionalization be halted immediately, at least until an informed, comprehensive evaluation is complete, and that congregate care remain an option supported by the Ontario government.

The deinstitutionalization process has certainly helped some people with mental disabilities to achieve some personal growth and goals in the community, particularly those who are mildly retarded. These people were discharged first and moved into the group homes. However, those left in the Rideau Regional Centre with profound and severe mental problems cannot cope in a community setting. All need 24-hour supervision and long-term care. Their discharge into the community is not going to magically cure their conditions. Their discharge will not magically alleviate any of their symptoms. In fact, the evidence to date suggests that their discharge will exacerbate their conditions and threaten their wellbeing.

The medical needs of these people are five to seven times higher than the so-called average person. Disproportional frequency of cerebral palsy, heart problems, Alzheimer's, hepatitis B and choking are typical serious medical problems that not only demand vigilant, qualified staff supervision but also specialized medical care by practitioners who are trained and experienced in working with developmentally disabled patients and who have expertise in the aspects of the disease particular to the mentally retarded. This is a long-term care issue that requires an extremely specialized resource pool that is unlikely to be found in any average community or even in a community supporting a group home.

To illustrate this point, I would like to refer to two situations. Firstly, the leading cause of death among residents of Rideau Regional Centre is choking. This problem appears among a disproportionate number of residents because of the underdeveloped swallowing mechanisms, epilepsy and the effects of anti-convulsant medications. Highly trained staff with appropriate backup medical support must be present for crisis response and intervention to maintain this horrible statistic even at its present level.

Secondly, it was the recent experience of one of the federation institutions that decentralized medical services to the community level that the medical needs of the residents could not be adequately met. From simple waiting room problems to more difficult hospital stays, the problems that presented led to a quick reversal of the decision

and medical care was administered in the facility, where the patients were comfortable and the practitioner was familiar with required specialized procedures. Quite a simple analogy would be the rationale for the existence of children's hospitals.

Does it not tell us something when our institutions are being visited by delegations from the United States and Europe? The computer technology and swimming programs at the Southwestern Centre have given it the reputation as state of the art for long-term care and programming for the developmentally disabled worldwide. Is it not logical and humane to consider such operations as best practice, avail the same opportunities to residents of other facilities in a very cost-effective manner and consider such institutions a valuable, viable long-term care option, rather than charging forward in a frenzied, blinded determination to close such institutions?

Until the deinstitutionalization process started, residents of the Rideau Regional Centre and their families felt secure that their loved ones would be taken care of. For the most part, they were pleased with the growth and fine-tuning that created an adequate community. Now the security is no longer there. Community services are not being developed fast enough to look after this very fragile part of our society. Residents are being dumped into isolated group homes without any choice of social contact with their peers. Programs are being cut rather than enhanced. Once a resident is discharged, the ties have been permanently severed. The ministry has not seen fit to track discharged residents, nor use tracking in the evaluation of this policy. Tracking of the developmentally disabled discharged from institutions is almost totally ignored. This cannot be tolerated. It is the basis for accountability. The Ontario government is accountable for funded community services. Incidents such as the emergent closure of the Delbert Ranch Homes for the Autistic in Alberta raised strong concerns regarding arm'slength accountability in the private operation of long-term care group homes.

I strongly object to the related statement from the facilities planning project, central region, Ministry of Community and Social Services, May 1992, recommending the closure of Oaklands Regional Centre. I quote from that document:

"From this point forward, community-based services should be the sole model of choice in terms of program development. If future institutional care is deemed necessary, it should occur only through mainstream facilities, eg mental health, corrections, etc."

This population needs special care. Because of their disabilities, they age faster than the so-called normal population. They need intensive nursing care. They need 24-hour supervision. They need an opportunity for social contact with their peers. They need programs that can help them obtain some basic social skills, such as dressing themselves or toilet training, or the help of an occupational therapist in improving their motor skills. All their needs are looked after at facilities like Rideau Regional Centre. No one has ever given me a logical explanation why the Ontario government wants to close Rideau Regional Centre

and discharge the residents into isolated group homes without services to adequately look after them.

I'm not sure where the crossover is between the Ministry of Community and Social Services and the Ministry of Health regarding long-term care for the mentally disabled. Along with the authors of the above-mentioned report, I too, through unfortunate experiences, have made the connection to Corrections. Is this really what our government is seriously proposing for long-term care options for the severely and profoundly retarded—jail or the asylum? To me it makes Peter Gzowski's fruit bowl sound attractive.

The mentally disabled need assurances of long-term care facilities. Their aging families need assurances that the services will be there for them. Our society must recognize their needs and the perils presented in proceeding further without complete and objective evaluation. On behalf of these people, I ask that the special needs of the mentally retarded be included in plans for long-term care in Ontario.

The Chair: Thank you very much for your presentation, both for your personal comments—I think only those who are directly involved, as you are, can express those thoughts to us—as well as for all the additional material that you have provided at the back of your presentation. We'll move now to questions and begin with Mrs O'Neill.

Mrs O'Neill: I'm very pleased that the standing committee on social development has returned to Ottawa and has returned on a subject as important as long-term care, and I'm particularly happy that the Rideau Regional Centre is our first presenter.

The quotation that you have presented, "From this point forward..." has been presented to us before. It is a quotation I have a lot of difficulty with, because when we talk about a "sole model of choice," if we use any dictionary of the English language, we are assured that those two words, "sole" and "choice," have absolutely no relationship to each other. In the future, if institutional care is deemed necessary, it should occur only through—so we are being told exactly, in a very autocratic manner as far as I'm concerned, how people who have been very traditionally and very historically well cared for are going to be treated.

I asked the question of other presenters, particularly in the Toronto hearings, about how this whole thing got connected with mental health and Corrections. There were parents who were presenting to us from other facilities and I was most disturbed when I heard how Corrections got involved. I had not presumed that that's the only alternative in some cases. So I'm very, very happy that you've come forward with particularly such a personal story. Have you, with your executive—and I understand you're a member of the executive, Molly—thought about how Bill 101 could be changed to include you? Maybe I could help. Have you seen it as part of the broadening of the direct funding model for the physically disabled, or do you see yourself in another part of the bill?

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Ms Morris: I have been looking at some materials regarding Bill 101, and I can't put my fingers on them at the moment, but I remember a document that specifically

referred to institutional versus home kind of funding. I don't know if that's sort of a skirting, round-about response to your question, but there certainly needs to be, in my belief anyway, a congregate care facility model.

My concern about indirect funding and arm's-length kind of accountability is the very concern I raised with the Delbert Ranch Homes for the Autistic in Alberta. Where there is an appointed or an elected board of directors, accountability on a volunteer basis is a safeguard but—I guess my concern comes partly too from dealing with such vulnerable populations. I'm not anxiously looking forward to the day when I'm in an institution, but I can just see myself being this little old witch with my mental facilities still about me, and I have so much more power at that point than do the people I'm representing tonight.

So I guess the answer to your initial question is no, I haven't come up with a solution, but I'm concerned with the haste—even though it seems like a long period, 12 years, that they've been trying to close institutions like Rideau Regional Centre—and with the lack of evaluation and scientific study of the outcomes and without looking at the cost-effectiveness of caring for people in institutions, as far as the people with severe, profound problems and with extremely high need I'm representing tonight are concerned.

Mrs O'Neill: I guess what you're saying is that you're challenging those of us who have an opportunity to place amendments that we would include you in Bill 101.

Ms Morris: That's correct.

Mrs O'Neill: Certainly you're not the only one across the province who's done that, and I think that's what's healthy. We've heard the very same message right across the province regarding the developmentally disabled who are already in congregate care. So thank you so much.

Mr Randy R Hope (Chatham-Kent): Thank you very much for the presentation. In your story today, you made reference to the one in the southwest area, the Southwestern Regional Centre, which is in the neighbouring riding to mine. I know through the family auxiliary I've got myself into some trouble at times about some comments that I've made, but I know, through the families, they've expressed the same concern that you have. I guess a lot of them were saying, "Where does this all fit with long-term care and the multi-year plan, and where is this all put into place?"

I understand your concerns about those with multiple disabilities being able to work in the community or make do in the community, and I guess it's hard for most people to understand, unless they've been to one of the dances that are being held at the centre or participated in the fun day programs that are out there. They have a hard time really understanding what these people are coping with or what the individuals are coping with.

You're saying, "Where does this fit with long-term care?" I guess I have to ask the question, doesn't the multi-year plan, which was initiated by another government, take care of those who are developmentally disabled or mentally disabled? I know there are conversations taking place right now about the multi-year plan phase 2—I guess plan 1

wasn't all there, so there's plan 2 that's now being developed—and I'm wondering what you see yourself in the context of the work that's taking place around the multi-year plan in the context around long-term care.

Ms Morris: One of the comments that I'd like to make about the multi-year plan, and it may not specifically answer your question, is that as well as Bill 101, one of the strong components of both of those documents is the input of the stakeholder, and it has never been the case of the multi-year plan, no matter which government was involved with it. It's a concern that when I see this on the piece of paper about Bill 101 and the stakeholders are to be totally and absolutely and completely involved in it, then I'm really concerned that it's going to be a similar kind of thing as we've experienced with the multi-year plan.

Mr Hope: So do you think then there's a possibility you're going to be missed on the multi-year plan and missed in the long-term care and you've fallen through this giant-sized crack, now sitting there and saying, "Oh my God, what happened?"

Ms Morris: Yes.

Mr Hope: Because when you raise your comments about the correctional institutions—and I can only assure you through my own belief—I've had great times out there in the Southwestern Regional Centre, and I would never want to see any of those individuals, who I cared about for years even before being elected member, being at the hands of the correctional institutions. I understand where your fear comes in-will they be missed in this overall strategic plan that's going on?—and I think what we as a government have to do is involve the parents and the family auxiliaries more in the process about their childbecause you indicated a lot of them are older now—being more heavily involved in the multi-year plan and heavily involved in making sure that when the long-term care discussion paper comes out in March that they're an active part of that whole process so that we can close the gaps.

I know where your fear lies. You've been through a process, a multi-year plan, and everybody missed the consumers' perspective or the stakeholders' perspective, and you don't want to have the same thing happen. But I can only assure you that I know, inasmuch as I'm still the parliamentary assistant over at the Ministry of Community and Social Services, I'm going to make sure that the institutions are not the corrections institutions, because I clearly understand your story. When I heard your story, it reminded me of John when he was talking about the first time he took his son into the Southwestern Regional Centre, and that story that you indicated to me was the labelling, I guess, that happened 10 or 20 years ago of those facilities. They were much different from what they are today. There's a whole different atmosphere in there.

Ms Morris: I think, as a parent and as a sibling and as the daughter of a family that's been involved for a long time with developmentally disabled people, the other thing that I really fear and have experienced is the kind of burnout and depletion. These aren't normal families, and the sooner the family that's involved recognizes that they're not normal any more and you don't fit into those normal kinds of molds—there's only a certain amount of energy that people like myself or members of any of these associations can expend for the protection of their loved ones and the people they care about; their friends, even, if they're not relatives.

Mr Hope: But you know there are advocates on both sides

Ms Morris: I realize that.

Mr Hope: The family auxiliaries are saying, "They're comfortable in the facilities," and then you have the advocates on the outside, Community Living, saying, "They're better off served in the community."

Ms Morris: You know, something that just popped into my mind is the non-smoker's rights kind of thing. Do you have to be forced to breath my smoke just because you have your set of beliefs about smoke?

Mr Gilles Bisson (Cochrane South): Good point.

Mr Hope: I'm a smoker.

Mrs O'Neill: That's a bad example.

Ms Morris: No, I think it's a very good one. That's why I chose it. Because one kind of service model fits the needs of one individual, it doesn't answer the need of others. Should they be denied their right to the appropriate kind of care model that fits them because it's the trendy, philosophical kind of thing that's required?

In my submission I'm sure you got the feeling that I did not always love, and I still don't love, Rideau Regional Centre, but I think it would be a crime to close that institution. As I've said before to officials of the Ministry of Community and Social Services, it's like somebody expropriating my brother's home. He's lived there for 39 years.

Mr Hope: But the intent of all centres is to actively prepare people for the community, and you're saying, if they go through that process and they're not actively prepared to accept a community, then don't force them out to the community, if I understand you correctly.

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Ms Morris: I know how comfortable I feel here tonight and I have lots of faculties and I feel quite a bit, intellectually anyway, as if I'm with my peers. I adapt to change quite nicely, thank you very much. I know, in my experience with these people who live at Rideau Regional, that change is not an easy kind of thing.

Mrs Bradley: It's devastating.

Ms Morris: It's devastating to see the effects that have happened on some people. We can go into details about people becoming stones after years and years of work for small amounts of progress, and some simple change just throws things right off.

The concern I have when we abolish the option for congregate care is that one of the problems is the high staff turnover rate. It's incredible. You know, it's also in the document that I was reading before I addressed this committee, the concern about the preponderance of women in low-paying jobs being the care givers in long-term care facilities in the community. My concern is not only that,

but also I want to see continuity, and that's not happening in our region as far as community living options are concerned. The staff turnover rate is astronomical. The burnout rate is incredible.

Mr Hope: Just in closing, I understand what you're saying because, being the parliamentary assistant to the Minister of Community and Social services, I know at the Southwestern Regional Centre, which really touched me, there was a gentleman there who came up to me and said, "Randy, tell me I don't have to leave." You know, I didn't have an answer for him.

Ms Morris: We live in a world where there are no absolutes

Mr Hope: But I clearly understand your role. Thank you for praising the Southwestern Regional Centre.

Ms Morris: Congratulations if you had any part in its success.

The Chair: In ending this part of the hearing, perhaps I would be permitted a few personal comments as well, having been the Minister of Community and Social Services and having visited your centre several years ago and having met on a number of occasions with representatives of the parents who were there.

I think what I want to do is to tell you, first of all, how important it is that you and the other groups come forward and talk, because I think, as Randy Hope has noted, there are people in different places in terms of what is the best thing to do. In a sense, particularly for those of us who have not had the specific life experience that you have had—and you, as a daughter, as a sister, as a mother, see that in a way that those of us who have not had that experience can understand intellectually but can never understand in terms of the whole gamut of emotions that at times you must go through.

But I think as we go forward and try to develop both within the community and in other ways—congregate, however they're shaped—we're on a voyage and we're all learning. Each year I think we learn more about what we can do, about we can't do, about choice, about how we try to work with parents around what they believe to be the best thing, as well as to work with others who may choose other options.

In your presentation tonight—I think of other colleagues of yours before this committee—there's no question that, as members, I think we are very much aware of the dilemma that you have posed and how we then bring together both the long-term care development and the multi-year plan and work those together in a way that in fact will provide both choice and services that are required.

So I would, on behalf of the committee, like to thank both of you for coming, for your written presentation, but perhaps most importantly, for your own life experience and your own personal observations.

Ms Morris: I would like to simply point out that a very critical part of the written presentation falls on the very end of the presentation. It's a cost analysis of the per diem of some of the functional institutions versus—I think that's very interesting information that should be considered.

The Chair: And we thank you for that. Again, thank you both for coming tonight.

GLEBE CENTRE INC

The Chair: I would then like to call our second presenter, the representatives from the Glebe Centre, if you would be good enough to come forward. If we need another chair, I'm sure the clerk will be able to provide a chair, or two perhaps. Take your time. We can probably move a mike into a somewhat—

Mrs Colleen Henderson: It's all right, we can share that.

The Chair: Well, we've got extra mikes, so let's make use of them. We've lots of time, so we'll get ourselves organized first.

May I first of all, on behalf of the committee, welcome all of you here. We are very pleased that you were able to come, and if you would be good enough to introduce yourselves both for the committee and for Hansard, then please go ahead with your presentation.

Mrs Henderson: I'm Colleen Henderson, president of the Glebe Centre corporation and chairman of the board of directors.

The corporation owns and operates a 195-bed non-profit seniors residence at 900 Bank Street, and the Abbotsford House seniors drop-in and outreach centre at the same address.

I would like to introduce the directors of the corporation here tonight who will be assisting me by speaking to specific sections of the draft legislation under discussion. Mrs Madeleine Honeyman will speak to concerns respecting consumer choices. Mr Doug McKeen will address the impact we feel this legislation will have on the role of volunteer boards. Rev George Strong will identify his concerns as chairman of the pastoral care committee with the responsibility for the spiritual and psychological wellbeing of our residents. Mr Foulkes, who is the vice-chair of our corporation, will express our concerns for the future of our organization, particularly in relation to the building of our proposed nursing home.

We also have in the audience, honourable members, several people who are vitally concerned with the life and the future of this organization. There is Mr Clarence Young, who is chairman of our residents' service committee, and is himself a resident of our organization. We have Mrs Rutland, a resident, and we are proud to have supporting us Mrs Betty Donnelly, the representative of our employees union, the Canadian Union of Public Employees. Last but by no means least, we also have in the audience two past chairmen of this organization, Mr Charlie Hurst and Mr Don Evans. All of us, including the members in the audience, would be happy to respond to questions at the end of our presentation.

We come here tonight, Mr Chairman, in the spirit of cooperation. Our board, management, staff, employees and volunteers consider themselves to be partners with the ministry in the provision of services to the seniors of this community.

Over the years, we have developed a positive working relationship with ministry officials. This has translated into quality care for our clients, but with due respect to the ministry, I would say there is a third factor to this partner-

ship which has not been addressed by this bill, and that is the public at large.

I can say with some pride that the Glebe Centre has, over its long history, which stretches back over 100 years, been supported by the community in enormous and very significant ways. It is interesting to note that during this long history, we have never, ever had a deficit budget. The public has supported us wholeheartedly, and I believe that this stake, this shareholding of the public involvement in non-profit institutions, must be recognized by this legislation.

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We fully support the need for long-term care legislation and we wholeheartedly subscribe to the four driving principles, namely the privacy of the individual and the right to dignity, security and self-determination; the promotion of racial equity and respect for cultural diversity; the importance of the family and community; and equitable access to appropriate services. However, in our view, certain aspects of this legislation appear to work against reaching these objectives. We will try to explain these points as we go along. I will now hand the microphone over to Mrs Honeyman.

Mrs Madeleine Honeyman: Good evening. It's a pleasure to be here, I think. That remains to be seen, I suppose, but I do want to bring a particular concern of mine, and that is the concern that perhaps the NDP is drifting away from the philosophy that I always thought they held, and that was a real concern for the autonomy of the very old, of which I am one.

Naturally, I don't care for this drift away from giving the right of choice to the very old, because we're a group of people who are more diverse, less homogeneous than any other age group. This has been proved by research over many years and by this new book that's just been put out by the National Advisory Council on Aging.

As a consumer, my major concern is the proposed new admission criteria that are to be administered by placement services. It seems to give an enormous amount of power to these services. It appears that I will no longer have a choice, or even two or three choices, of a place that I may want to go but that I will be directed to a particular facility. There appears to be no appeal against this decision, either for me or for the facility that will be forced to receive me.

It seems that this legislation, Bill 101, takes into account very little the fact of whether a person is heavy care, light care or able to look after themselves, and because of its peculiar build, Glebe Centre is really not equipped to take heavy-care patients. It's a 12-storey building with places for 18 people on each floor. There's a great risk, we feel, for these people if they are in the upper floors. It was never meant to be a nursing home. It's a residential facility for people who are able to pretty well care for themselves with some supportive services.

At the moment, because of the changeover in homes for the aged to service people who are more incapable—or sicker, if you like—we have now 22 beds funded for extended care, but there are 70 people in the building who have certificates to say they should be getting this care. We

are caring for them, certainly, but we're not getting the money for that.

Money also is a problem. If we are forced to take many more heavy-care people, where's the money coming from? We couldn't put them on floors without a nurses' station, and that would be an astronomical cost to put a nurses' station in for 18 people. The building would have to be adjusted, which would be another cost. One thing we're very pleased about is that the bill states that there's proposed capital funding for non-profit agencies, but we are concerned about how that could be accessed in the short

Glebe Centre, like many community agencies, has people who look forward to coming there when they can no longer stay at home. There are people who have been volunteers, have been directors like we have been, have worked in the place or have seen it grow and just plan that this is where they're going to spend the last days of their life.

In conjunction with this, I'm terribly concerned that I've never heard one word from any of the people I visit all the time in care facilities who know one thing about what the government is planning. None of the residents, who are the most concerned, seem ever to have received any information from you people, and that is certainly a concern.

In this new publication, the word "needs" and "choice" occur over and over again in the recommendations of the council on aging for the future of the very old. I see nothing in Bill 101 that gives any of this choice. I'm afraid to mention that word "choice," and you notice I'm not putting "sole" in front of it. I want to be very careful that I don't upset you.

The other thing is that moving into a known place is recognized as the best way to keep older people from suffering stress moving from home into a unfamiliar situation. Making choices about how to live out one's life is basic to the individual, basic to his sense of self-esteem and dignity.

I know how much money it's costing for our health care system, and we recognize that perhaps in the future we may have to pull the plug on some technological treatments for older people, but please don't pull the rug out from under our feet now. Thank you very much.

Mr Doug McKeen: As a fully accredited facility with a long-term positive reputation in our community, the Glebe Centre volunteer board of directors and the volunteer committee members are extremely concerned that the proposed legislation's tone and flavour appears to give an aura of mistrust. It is very evident when you go through it, and as a volunteer board member, I've taken a look at it. This questions our long-standing partnership that Glebe Centre's enjoyed with governments at all levels and of all parties and we're wondering what's wrong with that. We feel that we're highly committed and responsible stewards for our facility and our residents and are most uncomfortable with an intrusive inspection process that has been proposed. We find that it's going to be a major problem.

We've always been accountable to our clients, the residents of the Glebe Centre, and to our local community

throughout our long history, and our history is there for anyone to look at. Our board of directors is composed of professionals from all walks of life who take their fiscal and administrative roles extremely seriously, and I think it's evident by the volunteers who have come out tonight to be present and with us tonight. We are curious as to what has happened to cause such a radical departure from proven past and current methods of accountability. Might this be an example of fixing something that isn't necessarily broken?

We also have serious questions about our continued ability to attract and retain high-quality board members when we see our responsibilities, particularly fiscal, increasing while our direct control over per diems and admission policies is greatly decreased. Our ability to generate much-needed revenues is seriously limited by the proposed policy of decreasing revenue paid by those residents who have the ability, the resources and the willingness to pay. Why?

When you consider all the restrictive controls that are being considered in this legislation, it would be most difficult to justify serving on such a board. When one adds the legal responsibilities imposed on board members, I for one would really have to consider my continuation as a board member.

Finally, community fund-raising by groups such as ours has become extremely and highly competitive and a costly undertaking, in many cases requiring the services of professionals to achieve the results that are needed. We wonder how we will continue to fulfil our fiscal obligations under such circumstances.

Fellow director David Foulkes will now take a peek into the future of the Glebe Centre.

Mrs Henderson: Can I perhaps correct that? It will be Reverend Strong who will speak.

Mr David Foulkes: I missed a meeting. **1930**

Rev George Strong: The Glebe Centre Inc, a charitable home for the aged, has its 100-year-old origin as well as its present operation rooted in a religious and humanitarian motivation to fill the needs of elderly persons in the final years of their lives. In the nearly 20 years of my association with the Glebe Centre, I have observed this organization demonstrate its ability to practise such motivation on behalf of aged residents. It is from this experience and my own special interest in the spiritual care and mental health of persons who are 80 years of age and over that I look at the proposed act, and from my perspective as a pastoral perspective, I find a major problem.

I underscore two aspects of the proposed act which, from my experience, I believe can jeopardize the spiritual wellbeing and the mental health of perhaps many very elderly persons. These have to do with (a) one's entrance eligibility for residence and (b) one's personal decision-making as to what residence, that is to say, the right to reside and the right to decide: reside and decide.

Example 1: Let's say a couple has been married 50 or 60 years. She needs help. He is not able to carry the load. The proposed act would require these people to live separately.

While one person is eligible for residence, the spouse is not eligible. Hence, they are required then to live separately. I find that most jeopardizing to the final years of life of these sorts of persons.

Example 2: Let's say a person has lived for a long number of years in a certain neighbourhood in a city and wishes to choose a charitable home in some proximity to those old, familiar streets and places. The new act would require that said person take what comes, not being able to choose—that's what it says, not being able to choose—the location one would want. You take what comes.

To conclude these remarks, I would say my experience is that the spiritual and mental health of elderly persons can be strengthened when they are able to make decisions for themselves: the right to reside with a non-eligible spouse and the right to decide the facility for one's residence. The new act eliminates personal decision-making as to where and with whom one may live.

Mr Foulkes: My name is David Foulkes and I'm the vice-chairman of the board. I'm asked to talk about the future, which incorporates the present leading up to the future.

The Glebe Centre has spent 10 years, \$1 million and many thousands of years—sorry, many thousand of hours of time to develop a proposal—

The Chair: It just feels like it.

Mr Foulkes: Some days it feels like it; you're right, sir—to build a nursing home project on the adjacent property that's owned by Glebe Centre. You've heard people talk about the building and the tower we have now, which is residential. We've redone Abbotsford House, which was the original home, and that's the senior citizens' drop-in centre. So it was a natural progression for Glebe Centre to build a nursing home so it could cover the whole continuum of care.

We have the support of the government. We have the support of the district health council. We have the support of the council on aging. In fact we've had the support of every government that's been in office in Ontario in the last time.

This set of drawings is the approved drawings by the Ministry of Health. In 1986, the first person who approved the project was Murray Elston. The person who issued the licence is the honourable Elinor Caplan, who's sitting at the table this evening. I'm pleased to have her here. She issued us a licence for 70 beds back on May 6, 1988.

We agree with the long-term care and what is being done, and we've gone progressively along with this. As a matter of fact, we've got several pages of people we've talked to, representations we've made etc, and we've been approved by the Conservatives and licensed by the Liberals and encouraged by the NDP. In fact our past chairman wrote a letter, seven of them, to the Premier and the Premier, Mr Rae, has written a letter back to us saying that they want to help us and please go ahead.

The federal government, under the Central Mortgage and Housing Corp, must ensure our mortgage as a charitable corporation. This gentleman, Mr Bennett, has said:

"Yes, we'd be happy to do it, but you fellows have a problem. You can't make the mortgage payments."

When we look at the per diem rate that's proposed for nursing homes, the proposed funding would appear to us to be a cost of about \$38,000 per bed. According to our figures research and the assayers on our drawing on this approved building for 112 beds, the cost of those beds is just twice as much.

The only way to do that would be to cut down some of the other facilities. In there is a 46-bed Alzheimer unit, which is something we desperately need. There are people currently in the Riverside Hospital, the Ottawa Civic Hospital and other hospitals that need this kind of care.

It's a question, as you know, of you've got a closed amount of money and it's redistribution of those funds, so we're here trying to get you to help us redistribute some of those funds and put up this nursing home. We've looked at a lot of these ways of doing it.

We also have to tell you that we know the Ottawa Centre Nursing Home is closing and the community is losing 100 beds.

We were invited by the district health council to go to a meeting with everyone else who has licensed beds. We have a list of all the people who have licensed beds.

We said we'd take the leadership role. We convened a meeting just recently in Glebe Centre. We had all these people here. We're the only people with land, we're the only people with the money, we're the only people with the approved drawings and we're the only people who can proceed. In this \$8-million building, there are a lot of construction jobs, the interest rates are right, everything is ready to go except one small thing called catch-22.

We've gone out to the community; we've raised \$1 million. The \$1 million is in the fire safety elevator that we've built, and Community and Social Services helped us build that elevator under cost-share. We renovated Abbotsford House—we spent \$1 million on it—for that drop-in centre, and we take care of the Glebe and several other areas in the region. We've invested about \$600,000 or \$700,000 in these plans; we've had a tender; we have equity of \$14.5 million on the property. You're looking at a whole bunch of frustrated people who want to build you a nursing home and we just need to get you to help us do it. If we can do some kind of cost-sharing for part of it, at the current rate we could assume and pay for a \$4-million mortgage. We've raised \$1 million. If there's cost-sharing in the legislation that can match us for \$1 million or \$2 million, we can put this place up.

I think that just about does it for me, so I'll turn it back to Colleen Henderson to conclude.

Mrs Henderson: In conclusion, we would like to distribute our written brief, which expands on the points we have made today. We would also like to express our thanks for the opportunity to appear before you. We wish you well in your deliberations and express the hope that the work of the task force will be expeditiously concluded. Agencies such as ours have been waiting anxiously for concrete direction from the ministry vis-à-vis funding and other matters. This bill must go forward quickly so we can

make the decisions that are so badly needed and serve the community as we wish.

The Chair: Thank you very much, and thank you for the way in which you've made your presentation. I think we all have a sense of the Glebe Centre from having each of you speak to a particular point and, along with your brief, that will give us something to take away. We'll begin our questioning with Mr Jackson.

Mr Cameron Jackson (Burlington South): I listened very carefully to your presentation, and of course you began with the focus on Bill 101 and then completed with your frustration with not getting a shovel into the ground. I'm going to dwell on the latter, since this is new information for me and I'd like to learn a bit more, if I may.

In the two years plus that the new government has been in power, have you had opportunity to speak with the local NDP cabinet minister, who was the Minister of Health for a while and then became the Minister of Housing? It strikes me that she's in a very powerful, pivotal, informed, potentially helpful position.

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Interiection.

Mr Jackson: Sure, go ahead.

Mrs Henderson: The past chair, Mr Don Evans, who is here today, and a group of people have talked to the honourable member you mention in the last two years, but not very recently. In fact, we have had difficulty in even getting to first base, so to speak, our foot in the office, in recent years.

Mr Jackson: Well, I'm a little concerned here because we know that this government has been contracting—not in the legal sense, but reducing—the total number of available beds, whether it be chronic care hospital beds, nursing home beds, homes for the aged beds or whatever, and that we're currently developing legislation in that framework. That has to be very frustrating for you, knowing that all those trends and the lack of support is moving in that direction.

I hate to be specific, but I want to get a sense. You said there was another facility that was closing and this was due to financial reasons. Is this a nursing home? Where? Has the government approached you about their licence, or the transfer of that licence? I'd like, for the benefit of the committee, to get a little better handle on that.

Mr Foulkes: My understanding is the Ottawa Centre Nursing Home was placed in receivership and is under a court-appointed auditor. It's Coopers and Lybrand, I think. Have I got the right name?

Mr Jackson: Was that privately owned?

Mr Foulkes: It's a privately owned nursing home that is technically—well, it's bankrupt. Their debt structure is such that the court-appointed administration, if I can, or liquidator, if that's the proper terminology, has asked and has tried to sell the licences. As a matter of fact, what they tried to do was move the licences from Ottawa to Toronto or some other area. The district health council contacted people and the district health council objected and blocked the sale. Then they tried to transfer the beds, I believe, to

Hawkesbury. The district health council went in again and blocked the sale because Ottawa is already underbedded by the statistics and will become further underbedded.

Mr Jackson: Are they moving the residents slowly out of the facility or not?

Mr Foulkes: I can't answer that.

Mrs Henderson: I can. Some of the residents have already been moved, and one of them is actually here tonight, having moved to the Glebe Centre.

Mr Foulkes: But not from the Ottawa Centre.

Mrs Henderson: I stand corrected on that.

Mr Jackson: It would appear then that the government is prepared to allow this licence to lapse or to fall, that it will just be returned to the government.

Mr McKeen: At this moment it's still an asset of the bankrupt corporation.

Mr Jackson: But the receivers have put a value on it.

Mr McKeen: Yes, they have.

Mr Jackson: I've had experience in my own community with Ms Caplan, who isn't in the same political party as myself, when she was the minister, and the future horizon for these facilities when they're about to fall is not positive, because the government's not prepared to move in and begin operating them. That's a clear decision of the previous government and of this government, so there is a high risk that these licensed beds will be lost and that the licence will just simply be returned because the receiver is now losing money at a great rate.

I'll yield to the next line of questioning. I appreciate very much your point about the lack of information for seniors generally, that the government's moving forward with a portion of long-term care reform without scoping out the entire horizon and filling in the picture for seniors. We're getting very little information out as to how this is being done. This is only a small part of long-term care reform and it's out of step with the other two pieces. Thank you for your input.

Mrs Honeyman: I just don't want to think you're doing that because we're old and we don't know what's going on.

Mr Jackson: Well, I'm not a member of the government. I wouldn't have done long-term care reform in the fashion it's being done, but they're the government of the day and they're to be held accountable for the manner in which they wish the public to understand it or to accept it or to fall for it.

The Chair: Thank you. Mr Bisson.

Mr Bisson: I'll be very short, if that's all right.

The Chair: With the pressures of time, we have time for one, and the parliamentary assistant will have some things. You may have the normal rotation, but either one, it's up to you to determine.

Mr Hope: It doesn't matter if you're quick.

Mr Bisson: Just a couple of things. One of the things—I've forgotten your name. Sorry, I didn't get a chance—

Mrs Honeyman: Honeyman.

Mr Bisson: Mrs Honeyman. Thank you. One of the things you had raised was the question around the information being distributed around to seniors in regard to what Bill 101 is all about and what the implications are and an opportunity for seniors to have input, something that is probably not the first time we've heard it, not so much from seniors, but we've heard it actually from associations. As much as the committee has tried to be able to get the information out to people in order to be able to comment and as much as the ministry has tried through various associations and through different mechanisms that are in place to get the information out, it's fairly apparent that no matter how hard you try, you always miss somebody.

I'm just wondering, how would you see a mechanism working in regard to making sure that the people in the end, who are the end users, have an opportunity for comment, if you have any suggestions?

Mrs Honeyman: You're speaking about the fact that I suggested that people in care facilities didn't hear this.

Mr Bisson: Exactly.

Mrs Honeyman: Now this doesn't apply to Glebe Centre, because our organization really gets out to the people in the home and tells them what's going on, as much as we can tell them, because there were some things that were not very clear. I'm well acquainted with a lot of other homes for the aged and other nursing homes around the city, and the ones that don't have a good working group inside, a residents' council for instance, never seem to hear.

I wonder if the heads of the homes for the aged, the executive directors in nursing homes, for instance, get a clearly written thing to say, "This is what's going to happen and it's going to cost them \$10 more a month" or "\$10 less a month" or something like that. Does something like that go out to the heads of all these organizations so they can actually get these people together and say, "This is what's going to happen"? Because what I hear from the people is, "We're terribly scared we're not going to be able to afford to stay here any longer because it's going to do such and such." I can't even truly clarify that for them.

Mr Bisson: That's in the vein of why I've asked the question, because like all other members who are sitting here, we have an opportunity to go into various homes for the aged, municipal homes, for-profit and non-profit, various types within our riding, and it's fairly apparent that often the seniors are not as well informed in regard to some of the things that would maybe affect them. I just wanted to raise that, because if we don't find a way of being able to get the information out, a lot can be misconstrued about what's being done and some of the things that you raised.

I think the parliamentary assistant wanted to respond to them, but I just wanted to say, one of the things you raised was a question of choice, and I think you need to understand—and I'm not going to dwell too long on it—is the question of choice in regard to having the ability to say, "I don't want to be able to go in that particular home," is a choice that you will still have under the legislation. What long-term care is about is making sure that there is a

multitude of options open in how we care for seniors and how we care for people as time goes by, not just in an institutional setting but also within a setting at home. I'll leave that to the parliamentary assistant. I'll stop at that point because that's basically my question.

The Chair: Ms Caplan. I'm sorry. Did you wish to comment?

Rev Mr Strong: I just wish to ask where that point is in the act.

Mrs Caplan: I can address that.

The Chair: We'll come and deal with that, but I want to go first to Ms Caplan and we'll end with—I'm sorry?

Mr Foulkes: All I wanted to comment to the gentleman was that I used to work for the income security programs branch, better known as the old age pension. Every month we sent out information, and I know if the province of Ontario asked the federal government to put something in the old age cheques that are mailed within Ontario, you could start giving small snippets of information. I wouldn't try to give somebody a whole lot, but often members of the family will be opening this up, depositing the cheque, and that does give you a mechanism to in fact get something into these people's hands.

Mr Bisson: That's why I raise it, because we do need to find a way to get people information so that they can look at these issues and say, "Listen, this is how I feel about them; this is my view."

Mrs Caplan: As the past, past, past, past Minister of Health, I am very familiar with your project and your centre and also with the development of long-term care and how much it has changed in the last two years, and I share some of your frustration and a whole lot of other frustration. But we do have an opportunity at this committee to turn nice words into protection in the law.

So in the time that I have, which isn't too much today, I'd like to ask your advice on some proposals for amendments that might deal with the issue of choice and tone and flexibility, and we've heard it over and over again as we've travelled the province.

The first would be a statement of principles. You referred to the principles that the discussion paper was drafted on. We actually had a statement of principles suggested by a placement coordination service; I believe it was in London. I read it into the record. I don't have time to do it again. We can send you a copy, but it seemed to me to embody those principles that you've mentioned.

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Would you like to see an amendment which included a statement of principles that would guide both the placement coordination service and the—what are they calling it now? The single access organization was ours; yours is the—

Mrs O'Neill: Multiservice agency.

Mrs Caplan: —multiservice agency, as well as embody for any of those interpretations of this law the statement of principles to guide the legislation?

Mrs Honeyman: At least it would prove that there was a choice still there. It's not much of a choice if you

have to say, "No, I'm not going to that awful place because it's 20, 50 miles from my home." That is not a choice, in my mind.

Mrs Caplan: What this particular statement of principles would do is say that all of the decision-makers within this bill would take into consideration the multicultural, the linguistic, the social needs of those people who were applying for service under this legislation. That would guide the decisions, but I think it has to be stronger.

Another amendment that I hope the government will bring forward, but if they don't, I hope they will accept if it's brought forward by other members of this committee and the opposition parties, would be the right of refusal by an institution on the basis that it could not provide appropriate care. You would support that kind of amendment?

Mrs Honeyman: Absolutely.

Mrs Caplan: I believe, and I want to ask your advice, that that amendment should also be subject to appeal by the client. So if there was an individual who said, "I want to to go to the Glebe," and the placement coordinator said, "Yes, we think you should go there," and the Glebe said, "We don't think we can provide appropriate care," that client should be able to appeal your refusal to admit.

Mrs Henderson: We would be very happy with that sort of proposal, but I think more than just statements in principle, this must be embodied in the act in a very clear, concise and explicit way.

Mrs Caplan: Those are two concepts. The first that I discussed with you was the statement of principle. The second was a specific amendment that would allow the right to refuse to the institution and that would be the right for an individual to appeal, clearly stated within a time line, the decision of a placement coordinator, coordination service. That would be a third amendment. How do you feel about that?

Mrs Honeyman: I guess it starts a little bit before that. If the criteria are laid down by the province, whatever group does this, and those criteria are handed to the placement service or whatever it's going to be called, how much is it going to be held to those criteria and not have any flexibility itself? It's flexibility that really needs to go in there between the government and the placement.

Mrs Caplan: It's my view—and again, I'm not a lawyer; I'm a lawmaker, as a legislator—but that's where I think the statement of principles might help, because the statement of principles would give the flexibility to a placement coordination of the things that it had to take into consideration while determining an appropriate placement. If you had the right of appeal, Bill 10, do you think that might give greater flexibility and greater choice to the legislation? Do you follow the proposal?

You don't have to answer today, but if you'd think about it-

Mr Foulkes: We'll answer today.

Mrs Honeyman: Yes, I'd be happy with that.

Mr Foulkes: Yes.

Mr McKeen: It certainly would, your statement of principles, and I guess the legal thing would be the ques-

tion of whether that provided a loophole and whether that just provided the organization with too many discretionary powers. I think that would probably be your hardest sell. I think that would be one that would have to be addressed. But we've outlined, by example, real conditions that are out there, and I'm sure that any one of your members at the time of decision-making to go into a home would like the same options that have been presented to you today.

Mrs Caplan: Now the next-

The Chair: Ms Caplan, please put another one, but if you could, bring it to a close.

Mrs Caplan: Okay. The last was on the tone. You've said that you're an accredited facility. I'm assuming that you have a residents' council and that you have a quality management program in place. If instead of the intrusionary powers and the negative tone there was an amendment that said that provided you had a residents' council that was active, that could be judged on the basis of its outcome and participation, provided that you had in place a quality management program, and if you had achieved accreditation, would you be comfortable then that there was sufficient accountability that you could be excluded from the inspection powers of this legislation? Would you feel that would be a good balance?

Mrs Henderson: Yes, I believe that would be very acceptable to us.

Mr McKeen: And I guess it has to go back and ask the question as long as you would be acceptable, because you're the one who's been proposing to impose all these new—

Mrs Caplan: Not me.

Mr McKeen: Right. The royal you.

We're saying that if we haven't done our job properly, we've been answering for over 100 years directly to our residents and directly to the immediate community, and we say: "Hey, we really feel that we've done a good job. We have our records to back that up. We've been completely open. We do an annual audit, as required. It's available to anybody who asks for it. Our meetings are open to the public," etc. We're saying, "What's wrong?"

The Chair: Thank you. Sorry.

Rev Mr Strong: I was just saying I think we would be pleased in that statement of principle to have a word about non-eligible spouses, and spouse to include, say, a brother or sister, that sort of thing, but a non-eligible person who wants to live together in the same residence.

The Chair: Thank you. I'd now like to ask the parliamentary assistant to comment and I believe he has some questions of his own. You'll have an opportunity to go back and forth.

Mr Wessenger: Thank you very much for your presentation. I'll start with a question before I address some of your concerns. I understand you have a placement coordination service already in Ottawa. From your experience, is it working well?

Mrs Henderson: Yes, we've been very satisfied with

Mr Wessenger: My understanding is that the principles on which the placement coordination has been working will continue to be so in the future.

I might just sort of explain that certainly we are as concerned as you about the whole question of consumer choice. I think when you look at the whole question of consumer choice, in this bill we're only looking at the institutional sector, but we have to look at the other choices for people. For instance, the community sector obviously has to be a real choice for someone who elects to receive his or her care in the community and there have to be such choices as supportive housing, which I think are a very important part of the whole continuum of care, as well as the long-term care facility.

With respect to the role of the placement coordination, the whole principle on which that is based is, first of all, to explore with the client what choices there are available for his or her situation, as I said, both within the community and with supportive housing and then the various institutions. The client will make the choice of what facilities he wants to be on the waiting list for and the placement coordinator will determine his eligibility. Assuming their eligibility, they'll go on the waiting list. The priority of admission will of course be determined by the placement coordination in the sense that if there's a very high need and the facility is suitable for that person, then that person would be pushed up the list. You can well understand that the need is as important an element as choice. You have to give priority to those who have the greatest needs, obviously.

The legislation does already provide a right of refusal in it. The grounds are to set out by regulation, but the grounds are going to deal with the aspect of whether the facility is able to service the needs of the client.

I also note your concern about the aspect that perhaps you think only personal care and the nursing needs are being taken into account. The new manual is being drafted, or has been drafted, which will also indicate the need to take social considerations into account.

I don't know whether I've missed anything here. If I have, I'll ask ministry staff to pick up anything I've missed.

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Mr Quirt: No, I can't think of anything. **Mr Wessenger:** Okay, fine. Thank you.

Mrs Henderson: Sir, the comments you made just did not come through in the draft legislation. In fact, I have to say very clearly that we deem that document to be almost punitive. You know, the tone was, "Tut-tut, you're not doing a good job, so we are going to show you how to do it," and frankly we were quite resentful. It would be very helpful and some comfort to us if at the time of tabling this bill we had your regulations tabled as well to give us some comfort that what you are saying will indeed take place.

Mr Wessenger: Thank you.

The Chair: We could, I'm sure, spend the rest of the evening with you, and I apologize that one of the heavy duties of the Chair is at some point to bring a close to the discussions. But I do want to thank you all again on behalf of the committee, as I said at the beginning, for the manner

of your presentation. I think you've covered a great number of issues. I recognize we weren't able to discuss all of them, but we have your brief and we'll be able to follow up with those. Again, thank you very much for coming before the committee and I know we would want to wish you all the very best in the successful completion of those papers that are on your desk there.

Mr McKeen: Extreme déjà vu here. We've heard that before.

The Chair: Well, sometimes things need to be repeated and repeated and then they happen. But thank you again for coming.

Mrs Henderson: And I thank you on behalf of my group.

CANADIAN UNION OF PUBLIC EMPLOYEES, OTTAWA-CARLETON DISTRICT COUNCIL

The Chair: I would like then to call upon our next presenter, the representatives from the Canadian Union of Public Employees, Ottawa-Carleton district, if you would be good enough to come forward. Perhaps we can replenish some glasses there if you would like some water. We'll move those old glasses out of the way. I want to thank you for coming before the committee this evening. If first of all you would just identify yourselves to the members of the committee and for Hansard, then please go forward. Although we are a bit late, we will still have the full half-hour for presentation and questions.

Ms Betty Sommers: My name is Betty Sommers.

Ms Mary Catherine McCarthy: And I'm Mary Catherine McCarthy.

The Chair: I'm sorry, just again for the record, you're with the Canadian Union of Public Employees. Are you the president or executive director or is there any title?

Ms McCarthy: I'm the president of the Ottawa-Carleton CUPE District Council.

Ms Sommers: And I'm president of CUPE Local 870, representing workers at the Perley Hospital.

The Chair: Fine. Thank you. Please go ahead.

Ms Sommers: Thank you for the opportunity to present here today. My name is Betty Sommers and Γ m a hospital worker and have been for the last 15 years. Previous to that I have worked at nursing homes and homes for the aged. I represent the Ottawa-Carleton CUPE District Council, which represents many of the CUPE locals here in Ottawa. We wish to address not only the deficiencies of Bill 101 but also to speak to the larger context of which this bill is a part, and that is the government's attempt to massively restructure long-term care in this province.

This restructuring, which the government refers to as reform, has been taking place bit by bit and piece by piece. Many organizations, including our own, have objected to this incomprehensible approach, which refuses to acknowledge the interconnection of all parts of the health care system. Alter one part and another part is affected. Each is vitally linked to the other. Close down chronic care beds and there is a greater strain put on nursing homes, homes for the aged and community-based services. Cut

acute care hospital jobs, budgets and services and an array of home care services and supports become absolutely essential. The reality is that long-term care is a comprehensive system. Yet here we are once again, examining yet another part of this massive overhaul, Bill 101, in isolation.

We believe the government has chosen this piece-bypiece approach because it makes it harder for the public to
see the full impact of the restructuring taking place. CUPE
has extensive experience dealing with health care policy
and we can say, with regret, that in the end, when all bits
and pieces are woven together and all the legislation and
initiatives are in place, long-term care will have been fundamentally and irreparably altered in Ontario. In a few
years, what we will call long-term care will represent a
radical departure from what we have now. It will most
certainly not be a change for the better but will be a system
that offers a much lower quality of care and far less services and security to patients and their families.

Fundamental shift: The government is reforming and reshaping the system of long-term care in a way that will not serve the needs of present and future generations in Ontario.

There are three principles that shape the policy directions in health care delivery and that mark a shift in ideology and approach. First is the idea that there is something obviously wrong with publicly run hospitals and other public institutions and that the quality of care is inevitably better when it is provided in something called community-based services, or when it is given in a patient's home. The second and related idea is that individuals must bear significantly more of the burden of caring for themselves and their sick relatives. The third principle is that the private sector can provide care better and more efficiently than public or non-profit agencies can.

Looked at one at a time, these premises don't stand up to experience or common sense. When they are combined, unchallenged, in a government policy, they are the worst possible news for our health care system.

Bill 101 formalizes these new principles with respect to provision of service and basic levels of care that consumers can expect. The bill sends an unmistakable message that consumes had better not look to the province for any meaningful enforcement of standards, that they have only themselves to rely on. It also exposes a government that has given up on the idea of non-profit public administration of health care.

Consumers on their own: The bill does require the posting of service agreements, but what happens if the home does not meet certain standards or if there is an infraction? There is no protection for whistle-blowers and nothing that empowers residents, allowing them to act on their own behalf and in their own interests. It is the residents and employees who monitor the agreement better than anyone else. It is absolutely essential that union members and residents accompany inspection tours and that they be legally protected from owner reprisals for their cooperation. Inspections are conducted infrequently and the ministry has a bad track record in policing infractions. We are therefore convinced that these measures would go

a long way to ensuring better conditions in the long-term care homes.

Residents in nursing homes and homes for the aged have long called for greater influence in the design and implementation of the services provided in their institutions. We believe it is very important to make these facilities more accountable to the government, the residents and the people they serve.

Giving up on non-profit care versus for-profit care inferior: Between 1976 and 1989, in Ontario the percentage of private beds increased from 47% to 54%, making it the largest supporter of the private sector in the delivery of extended health services.

Also, the Ministry of Health has assured the for-profit nursing home industry that funding for homes for the aged and nursing homes will be equalized in 1993.

We are very much opposed to this funding plan. It will further entrench and enrich commercial nursing homes at the expense of homes for the aged. The only way to provide decent nursing homes is to remove the profit motive from their operations. The purpose of a nursing home is to provide care to ill and infirm people, not to make their owners wealthy.

We know of a nursing home in this region where funding has been provided for a specific service but the nursing home does not provide the service. It has been brought to the attention of the ministry but nothing has been done.

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It also means the loss of 1,500 jobs this year in Ontario in homes for the aged. This is appalling. We do not think that dedicated and experienced workers should be treated like this, especially since a real need still exists for their services.

The hospital training and adjustment program, known as HTAP, must be expanded to include all workers in the system. Additional and sufficient money to fund retraining programs must be job guarantees for workers who are being laid off as a result of this government initiative.

Through long and hard experiences we have found that the quality of care in for-profit nursing homes is generally inferior, as are workers' wages, benefits and working conditions. We also believe that the private nursing home industry in Ontario has not been adequately monitored or properly held accountable for the considerable revenues it obtains from residents and the provincial government.

In 1988, the Ministry of Health residential services branch changed its system of inspection from one of enforcement to one of consultation. The net effect has been to allow private nursing homes to remain largely unaccountable for the services they provide, except during the pre-announced annual inspections conducted by the ministry.

Inspection system seriously flawed: In 1990, the Provincial Auditor's report pointed out the flaws in the current inspection and compliance system. Here are some of the findings: Over 40% of the homes did not receive any visits in addition to the annual licence renewal; long advance notice of licence renewal reviews could allow substandard homes to temporarily comply with requirements; it has been our experience with the compliance system that it fails as an approach. For example, in 1984, 20 homes were

charged, 497 charges laid and 117 convictions resulted. In 1989, a year after the ministry changed its system of inspection, zero homes were charged, zero charges laid and no convictions. This situation cannot be allowed to continue. If the regulations are not tough enough, then they must be toughened up and they must be enforced.

Wrong assessment method: Bill 101 calls for residents of nursing homes and homes for the aged to be assessed and a plan of care developed to meet the requirements. We have some serious concerns if the assessment tool to be used is the Alberta classification system.

Residents are classified, at most quarterly, to determine the case mix, whereupon the funding of the facility is determined. We know of one nursing home here in Ottawa-Carleton that under the Alberta classification system was initially told its funding would be increased, or at least stay status quo, but now the employees have been told that the funding will be decreased.

Our concern is that patient assessments will be conducted too infrequently to address the real staffing needs required by patients. This will have a dramatic impact on the workloads of health care workers and on the level of care residents can expect.

Staff who work regularly with these residents must have input into the patient assessments. Assessments should be done on an as-needed basis when the medical condition of the residents change or deteriorate or, at a minimum, on a more regular basis, and the case mix index system must be revised to reflect actual staffing case loads.

Enormous impact and care slashed: Our population is growing and aging. Bill 101 and the government initiative on long-term care and acute and chronic care will have a huge impact not only on today's senior population but on all generations. Nearly one million Ontario residents are between the ages of 55 and 64 and there are over one million people between the ages of 45 and 54. This massive restructuring of long-term care that is taking place now has everything to do with the level of service, care and support they can expect to receive, but the shape of it is unmistakably and alarmingly flawed and regressive.

We don't have to wait long to see the real adverse impact of government policy on health care. At this time, hospital beds and services are already being cut and workers in the thousands are being laid off. In another few months, over 18 million paid hours will have been eliminated from the hospital system. We have been told that community-based services will fill the void, but we don't see many new ones being created to replace programs cut from hospitals.

As part of the long-term care reform, the government committed itself to transferring \$37.6 million a year from provincial hospital budgets to community agencies to beef up home care. But where are these agencies and the equivalent services? The cutbacks that have taken place in our institutions are only viable in the reality of a comprehensive home care service, but it does not exist. Clearly, the language of reform the government and the bureaucracy has been using is simply a cover for budget slashing and cost cutting.

Cutbacks and rationing unnecessary: There is money available in the system, and there is waste throughout the system. CUPE has spelled out crucial areas where substantial savings could be realized. We have said over and over again that large sums of money could be brought back into the system through a change in the fee-for-service system of payment for doctors.

In our submission to the Public Hospitals Act, we suggested that the government look at the high salaries of hospital executives and pointed to the 67% growth in the number of administrators over an eight-year period. Meanwhile, the number of staff providing direct patient services is shrinking.

The existence and growth of the for-profit service providers and commercial operators is a loss for every one of us. Precious health dollars that could go into better services and more jobs are simply skimmed off the top in the form of profit for them and a loss for us.

The government has put a huge emphasis on community-based services. At present, many services provided through public health units and home care programs are contracted with private medical companies.

The rapid expansion of the private sector into home care causes us great concern. In 1978-79, the number of hours provided for Ontario residents was 82% non-profit and 18% commercial. In 1988, the ratios had shifted to 62% non-profit and 38% commercial. At our CUPE Ontario health care conference last September, the then Minister of Health Frances Lankin stated that the ratio is now closer to 50% and 50%. We now know that the increase in the commercial sector has been at the expense of the not-for-profit system.

The suggestions for cost-saving within the system has not been kept a secret from the government. CUPE has emphasized them again and again, but it seems that nobody is listening to us. It is beyond our comprehension that instead of seriously looking at alternative measures to cut costs, the government opts to slash and burn its way through thousands of jobs and much-needed health services.

Restructuring of the health care system must be slowed: We must slow down the pace of these profound changes to our overall health care system, and especially the long-term care portion of it. Community services are not in place, yet we are cutting chronic and acute care beds and services. When examining Bill 101, we just see more of the same kind of approach that is happening in the rest of the health care system, more of the same rationing of service and care, more warehousing of the elderly and more nickel-and-dime care for the elderly.

All of us deserve better health care than this. It is, after all, our lives and health on the line. If we are to have real reform, reform that works for us and not against us, then we must have more space and time to tackle the really serious issues of health care. Also, the government needs more time and space to come up with a workable approach that can meet our health care needs in the years to come.

The Chair: Thank you very much for a full presentation and a number of issues that you've touched on. We'll begin our questioning with Ms Carter.

Ms Carter: As the Chairman says, there are a great many points there and I certainly can't take up all the ones that I would like to. I wonder if you can clarify something for me. You seem to be saying, early on in your brief—I think it's on page 2—that it's not a good idea to have more of this kind of care provided in the community rather than in institutions. Then at the end of your brief you seem to be saying that the problem is that the alternatives in the community are not there, which obviously is a valid point, that if we're going to de-emphasize institutions, we have to beef up the community side of it, and certainly that is the intent, that this is going to happen, and I believe there's about \$400 million being set aside for that.

But as you know, there's been a lot of public discussion. The government put out suggestions and there were enormous numbers of meetings, consultations and so on, and I think it was generally agreed that to emphasize the community side and to help people to stay in the community as long as possible was a good thing to be doing. So I just wondered if you can comment a little bit further on that.

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Ms McCarthy: I'll make a few comments on that. Our initial point was that there seems to be the assumption in health care restructuring that institutional care is somehow not the kind of care people want and that community care is sort of automatically better. We think in many cases community care may be the best care and also, at the same time, institutional care may be the best care for people. It just seems to be in the sort of language of progressive reform in health care that institution is bad, community is good, and we don't think it's that simple.

We believe that a shift to community care and progressive reform in health care is probably part of what may at one time have been a progressive vision of the government, but what we see and what our members tell us is that the quality of care in institutions is—you know, people with shorter hospital stays and sending people home with an intravenous and one frail, elderly person being expected to care for another frail, elderly person, when people working in home care are saying that the people who are at home are sicker and sicker and they can barely cope with the service. We see progressive reform is really downsizing, cutbacks and a serious strain on our health care. We would like to be part of a progressive reform in health care, but we find we are trying to hang on to and our members are wanting us to try to protect the services more than ever.

Ms Carter: Obviously it's not a black and white situation. Of course, there's always going to be a role for institutions, but it's just a question of getting the balance so that people are in the ideal situation for them. Do I have any more time?

The Chair: You can have one more question.

Ms Carter: Okay. There is also this question of the profit versus the not-for-profit, and of course as far as the community side goes, home care and so on, we've been hearing from a lot of for-profit providers who really feel that we're trying to phase them out, so there are certainly different points of view on that.

As far as the institutions are concerned, I think the new funding scheme is going to be much fairer across the board, and of course for-profit institutions are only going to be able to make profit out of the actual provision of accommodation, not out of providing health services or programs and so on, so they're going to be very limited in that respect. But if we were to go to a much more publicly owned system, which would not be against my principles certainly, the problem would be, I think, finding the capital to take over all those businesses. I just wonder how you would solve that problem.

Ms McCarthy: If I could just comment on that briefly. I think it's important for the government to at least state in principle that the government has the intention to phase out health care for profit in all areas of health care. We know that can't be done with the signing of a document, but we know that there should be a commitment to that and there should be a process put in place for profit to be phased out of our health care system, because there shouldn't be profit. The stories that come to us from our members, who because of whistle-blowing and the jeopardy that people would put themselves in with their jobs, are incredible. For people who have worked in for-profit homes and then work in non-profit and publicly run institutions, the difference is amazing, and I would think that this government should be dedicated to phasing out and keeping in mind that Ontario has the highest percentage of for-profit. That's a shame, and this government should be phasing that out.

Mrs Fawcett: I thank you for coming and making your presentation. Maybe if I can just pick up on what Ms Carter was referring to on the profit versus the private way of providing services, we really do want to make sure that people have a good choice of services so they can be comfortable in their later years.

I have a hard time trying to understand just why there isn't room for both so the choice is there. Right now, I think certainly the public system is given the first go as far as someone availing himself or herself of service, and then if that particular service cannot be provided—maybe there aren't enough, especially in rural Ontario and in some areas of our province. There just aren't enough care givers to go around. I'm talking about those being provided in the community. So the private companies have been able to pick up the slack.

I have met both public and private care givers, and both can do a good job. I have to look at page 4, and I know this is referring to nursing homes, but it's sort of in the same vein, and you say, "Through long and hard experiences, we have found that the quality of care in for-profit nursing homes is generally inferior". I've been in both kinds of nursing homes as an MPP, and I don't always find that. I wonder what proof you can give me that this quality of care is less because it's privately given.

Ms McCarthy: The proof is that there has been extensive research done by CUPE. We have research officers who talk to our members who work in both kinds of homes, and not to discount your experience or anything, but we have a lot of substantial research from our members.

people who work in the homes, who can make a very real case for the care being inferior.

Our other point on this is that there may be private providers for certain kinds of services, and I don't think it would be the intention of the government to get rid of everyone. Our main point is that public dollars should not be going that way, that if there are scarce resources in health care and if health care is so expensive, one of the ways to save money in the system is to not give it to for-profit providers.

Mrs Fawcett: I've always thought that if there is a problem, then fix the problem; don't cut it out. I mean, when in doubt, cut it out. I just can't see why. If somebody isn't providing the care, then that's the problem you fix. If there is a nursing home that isn't up to standard, then all right, go in there and do something about the problem. But just to cut it out—

Ms McCarthy: Well, we've heard many reports about inspections and then recommendations not being followed through on and it being worse in for-profit nursing homes.

Mrs Fawcett: Could I just ask one little more? At the Golden Plough Lodge in my riding, which is the county home for the aged, I know the director there is very, very concerned and worried because the Ontario Nurses' Association is at binding arbitration. They know that precedent has been set at a 29% settlement and they figure that's what's going to happen here. So all of a sudden that has to be addressed, because, boy, that creates a big problem. CUPE is also at binding arbitration, and she is assuming that there would be a fairly decent settlement there, because I think they're asking for 8% now. Whether they'll get it or not I don't know. But these are the real problems.

Is this the reason for the cutbacks in staff and so on? Do you feel there are going to be further cutbacks maybe after some of these settlements? Do you also fear that you won't find those jobs in the community because we're not ready with the services in the community where you might be rehired? I'd just like your thoughts on that.

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Ms McCarthy: In my experience, not very many nurses who work in nursing homes are registered nurses. Usually they're RNAs and health care aides, so I don't think part of a budget would be dedicated to registered nurses.

Mrs Fawcett: I believe it depends on the level of care then, doesn't it?

Ms McCarthy: Yes, but anyway I just don't think there's a large population of registered nurses in nursing homes.

The other thing is, the level of wages of even unionized workers in nursing homes is very low and any wage adjustment that would bring them up to even the low end of poverty line wages would probably be a substantial increase for many of them because a lot of them are still between \$9 and \$13, \$14 an hour. These are not highly paid workers, and it's very alarming for us in the labour movement to now think that those are the jobs we are having to protect and use as an example of a good job, because what's in the community if some nursing homes

are cutting back? The jobs as a health care aide for some private home care agency are barely minimum wage or above. It is a very serious issue that the good jobs have a low level of remuneration and what's in the community so far, because it is largely unorganized and it's still largely private. Homemakers I think is one of the very few non-profit home care agencies in this region. The rest of them are private for-profit.

Mrs Fawcett: There's one thing I think we can both be worried about. The classification system we hope will address all these increases, because I think that's a real concern. There definitely will be more cutbacks.

Mr Jackson: I'd like to thank both deputants here. Your brief introduces me to some new statistics and some additional information. I can't necessarily agree with your thesis on the not-for-profit and the private. I do understand what you're saying and I understand where you're coming from. What's more important is not what I believe, and maybe it isn't even as important as what you believe, but the government of the day has clearly made the statement that for-profit nursing homes are not poor-quality care. The Minister of Health is on record—that's an NDP Minister of Health-as the NDP Minister of Community and Social Services has said that private day care is not inferior or lower-quality day care in this province. That is the attitude and the position of this government now, so I'm not going to dwell on that part of it because I think it's more of a debate and less of an impact in this legislation. The government's intentions are clear. At least that component of it will be supported by all three parties.

I do want to pursue the point you raised on page 4, which I think would be helpful to elevate my understandings a bit more. I can't help but be struck, Betty, by the fact that you represent workers at the Perley Hospital and that the government's currently working to reclassify the beds, the levels of care. From all my years in collective bargaining, that's going to change staffing, big time. Could you enlighten the committee as to how that—tie that, because we're going to hear from the Perley tomorrow but I'm not so sure we're going to hear a representative of your union in that presentation.

Ms Sommers: I'm the representative.

Mr Jackson: Will you be in that presentation tomorrow?

Ms Sommers: No.

Mr Jackson: Good. Then for that specific reason, I want this to be our opportunity to listen to the workers at the Perley and maybe we could focus on that more specifically. That would help me, because tomorrow I think I'm going to get all of it from the administrators, who are walking on glass here, whereas you can not mince words and just lay it right out there for us. Could you enlighten us what you really mean by that, and that'll help me in my questioning tomorrow?

Ms Sommers: As for the Perley Hospital turning into a long-term care facility, that is true. The workers at the Perley Hospital have not had any input into this decision-making.

Mr Jackson: Negotiations.

Ms Sommers: Into these negotiations. We know there was supposed to be full collaboration between both unions and the institution. There was nothing done. Nothing was told to us. It was just under informal discussions with the previous president of my local and myself and the executive director. He let it out and said, "Yes, the board of directors passed it, but they didn't know what they were doing."

We have great concerns about this and we have contacted the Ministry of Health in Toronto to reopen these discussions so that there will be a full, open consultation process with both unions, ONA and CUPE, at the Perley. The executive director is aware of what our position is on that. We fully intend to follow that through.

Mr Jackson: The hospital training and adjustment program, including all workers in the system: Just tell us which ones are excluded and what impact it's—I understand it's a top-down process.

Ms Sommers: Mary Catherine works for-

Mr Jackson: Maybe Mary could help me understand all of that.

Ms McCarthy: The Hospital Training and Adjustment Panel was set up to deal with layoffs from public hospitals. That's all those public hospitals under the Public Hospitals Act. So psychiatric facilities and nursing homes or other institutions or facilities in health care are not covered at this time. I understand there have been some discussions between the Ministry of Health and the Ministry of Labour about possibly expanding or not, but it was a special program set up by the Ministry of Health to help laid-off hospital workers into training and help them secure jobs in the community as the system was being restructured.

The Chair: Again, there are issues I'm sure we could continue to pursue, but we do want to thank you for coming before the committee for your presentation this evening.

ONTARIO PSYCHOLOGICAL ASSOCIATION, EASTERN REGION

The Chair: If I could then call Dr Irwin Pencer, if I've pronounced that properly. The critical changing of the water that a committee has. Dr Pencer, I want to thank you. I realize we are running a bit late, but we will certainly give you every attention. Also, if I can say to Ms Cluff, who is somewhere in the audience, don't despair; we will be getting to you shortly.

We want to welcome you to the committee. While obviously Hansard and members know your name, perhaps you'd just tell us a bit about who you are for the record and then please go forward with your presentation.

Dr Irwin Pencer: Sure. I'm very glad to have the opportunity to be here tonight. I'm a clinical psychologist and I'm representing the Ontario Psychological Association in the eastern region of Ontario. I'd like to apologize for not having a brief prepared. At the same time, I appreciate being offered the time to present tonight. I could provide one at a later date.

The major issue I'd like to address is accessibility to those in need of psychological services at the time of admission to a long-term care facility and afterwards. I'd like to just do a bit of a preamble, and that is to describe a little bit the services that psychologists can provide, although I understand that likely you're all at least to some extent familiar with this. At this point in time, if you look around the province, psychologists are not employed in any capacity that I'm aware of in a nursing home environment or in homes for the aged. There are very few psychologists actually employed in chronic care hospitals. The following is a bit of an outline of the kinds of services psychologists can provide. I've just categorized it according to different characteristics.

(1) Assessment: What that means is the provision of psychological test materials and, along with that, clinical assessment of individuals presenting difficulties in order to determine the presence and extent of cognitive impairment, depression or other psychological difficulties.

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As you may know, psychology is one of the few professions designated the right to diagnose mental health problems under the new Regulated Health Professions Act. Psychologists receive extensive training in psychological evaluation through their undergraduate and graduate courses, and particularly at the doctoral level, which is the entry point at this point in time for psychologists into the profession.

Second is treatment. Direct: for example, therapy for depression. Indirect: for example, developing behaviour management strategies for individuals with special needs, such as Alzheimer's patients who are suffering, wandering or in whom there has been evidence of aggressive behaviour for one reason or another. Another example: providing support and help to family members to help them understand the nature of their loved one's illness and also to help them develop a means of coping with this illness.

Keep in mind that along the way you might be aware of some overlap between psychology and other professions. I'm not here to compete with other professions, just to point out how psychology can contribute.

Consultation is third. For example, with nursing home staff or home for the aged staff with regard to behaviour problems of residents, psychologists can provide an alternative method of treatment which does not use medication. Psychologists tend generally to be wellness oriented, tend to try to look at the whole person in context and are dealing very much with quality of life issues.

Fourth is training: Training care givers in effective interventions.

Fifth, and last but not least, is research: Psychologists undergo training which involves both clinical—that is, applied—training as well as research training. So they come out as scientist practitioners and can be very much involved in evaluating programs and outcome research.

Keeping in mind the training skills of psychologists, I would like to address the following aspects of the bill:

(1) Special needs of residents with mental health problems need to be more directly addressed. Some 75% of Ontario residents of nursing homes and homes for the aged have some cognitive impairment; around 60% have been described has having some mental problems.

(2) Academic training and career experience of the placement coordinator position is not specified, nor is how admission criteria are established. These individuals will control the admissions procedures and in fact may go a long way in determining where a person will go and what kind of needs he or she has.

According to the bill, each resident in a nursing home or home for the aged must be assessed and a plan of care developed. What is the true meaning of that term "assessment"? We have to keep in mind that we cannot use that term in a casual sense, particularly from the point of view of psychologists.

Some recommendations:

Specify the need for psychological or psychologist involvement in the assessment and treatment of those in need. At the very least, for example, provide the opportunity and specify this for consultation with the placement coordinator.

Training of front-line staff: We all recognize that the services of the psychologist can be quite expensive, particularly on a private basis, so it might be well to consider the value of this service in an indirect fashion by providing the knowledge to the care givers. That knowledge can then be applied in a direct fashion with ongoing consultation and by providing assistance for care givers and for the psychologist to deal in a more direct way with problematic behavioural management issues.

Another recommendation: In view of the lack of government coverage for psychological services under OHIP, and notwithstanding coverage for services under selected private insurance companies, recognizing that there is a limit to this coverage, I recommend the government develop a cost-effective means for reimbursement for psychological services.

The Chair: As you're aware, while you didn't have the opportunity to present a typed-up brief, that of course is in Hansard, so that we have that. We thank you very much for coming forward, not only as an individual, but representing your colleagues here in the eastern region, and I think in particular for your recommendations. We'll begin the questioning with Ms Caplan.

Mrs Caplan: As a former minister, I'm very aware of the important role that psychologists play in the delivery of health services, and I'm particularly supportive of one of the roles that you played today, that of the possible future role that is envisioned in particularly the development of community mental health programming. I see many lost opportunities, as we've seen a remedicalization of the health system in the past two years, in my opinion.

I believe that this government has placed a relatively low priority on mental health services and I think there are many examples of what's happened to mental health services in the province in the last couple of years. One of the concerns that I have, as I listened to your presentation, is that you seem to have been excluded from the discussion and planning, not only of this legislation. We heard from your association in Toronto as well that the possible role

for psychological services, not only as a part of Canadian mental health but long-term care in general, seems to have been overlooked or not considered. I just wanted to know if you knew of any consultation or participation of your professional association as these policies were developed.

Dr Pencer: Earlier on, I suppose it was last fall, into the new year, there were a series of consultative sessions that psychology took part in here in the Ottawa area that involved both attendance at the various focus groups in the Ottawa area as well as specific meetings planned with our regional manager. We were able to have a meeting with him—I believe he's here tonight, or was here—and discuss the concerns of psychologists. We certainly welcomed that and felt that it at least got on the record some of the concerns that we had.

Mrs Caplan: Did you see any of your recommendations, ideas or suggestions reflected in this legislation?

Dr Pencer: Not in a specific way, no.

Mrs Caplan: Are you aware or have you been informed of any plan to develop programs that would allow for reallocation to allow for an enhancement of psychological services as a part of long-term care?

Dr Pencer: No.

Mr Hope: If I understand through Elinor's questioning, what you're saying is you should be involved in the process of doing assessments. You were looking at the word "assessment" and saying, "Well, if you're going to assess an individual, you should have professional assessment," if I understand you correctly.

Dr Pencer: I think that goes without saying, that the assessments should be professional. In addition, they should be comprehensive, and that is, address the issues from a number of different points of view, not simply do an informal assessment or, for example, look at the Alberta classification model as a means of testing a person, but rather to look at it from a bit more of a sophisticated direction.

Mr Hope: What do we do with those individuals who are afraid of that assessment process, getting wrapped up in the medical model, for instance? I've heard the disabled community saying, "We don't want to be entangled in this medical model of long-term care." I'm just wondering how that would be perceived, to do assessments on individuals suffering disabilities under the changes in the Ministry of Community and Social Services Act.

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Dr Pencer: I would have to say this is the first time I've ever been referred to as being perceived as coming from the medical model.

Mr Jackson: You're not funded that way, that's for sure.

Dr Pencer: It's a very unusual characterization of psychological services. If you look at how psychologists are funded in a hospital environment and how often they deal with other so-called allied health professions and interact with medicine, it would become very clear that we aren't perceived as medically oriented.

But that was a comment. Your question, nevertheless, is a good one.

Mr Hope: Well, around the health, as soon as you're embraced in the hospital aspect you're considered to be part of the hospital model, and that's the way the client perceives it.

Dr Pencer: From the client. I would have to speak from experience, that is, the opportunity to see clients in a hospital setting for purposes of evaluation, and although certainly at the outset many patients, clients, are a bit upset or maybe worried about the interaction with psychologists for purposes of evaluation, there is a tendency—and this is pretty general—for clients to relax very soon after the involvement, with proper training in the sense of that psychologist as well as proper education of the client, so that they can relax and understand the purpose of the assessment

The assessment is geared to trying to understand as well as possible the client and often can take quite a number of brief sessions, because an older adult individual often has difficulty sustaining attention for extended periods of time. So all these things are taken into account, and although I agree with you that initially it might be a difficulty, I think it's a question of understanding and education.

Mr Hope: So if I understand your presentation—I guess I'm going to try to be as direct as I can—in order for it to be a picture-perfect process then, you have to be in the picture.

Dr Pencer: I certainly think it's vital that psychology's in the picture, yes.

The Chair: Thank you very much, Dr Pencer. There are some of us who were also members of this same committee when it looked at the Health Disciplines Act, and when I hear the terms "medical model" and "social model," I think we all sort of come alive and remember the deep discussions over just what constituted what and what kinds of changes needed to be done. We thank you again for coming to the committee this evening and for the recommendations that you provided to the committee.

LESLEY CLUFF

The Chair: If I might then call Ms Lesley Cluff. Would you be good enough to come forward? This will be our last presentation of the evening, but in saying that, Ms Cluff, let me say that we will give you our full and undivided attention. I know you've been sitting here for some time, and we do thank you for coming before the committee. Your brief has been circulated. Please go ahead.

Mrs Lesley Cluff: I will throw in a little part of my presentation—it wasn't meant to be a part of my presentation, but if I do seem a little bit tired, I have a splitting headache, and I'll tell you why. It's something that is not dealt with in the current system and isn't even touched here. The gentleman from the Glebe, I noticed, did comment, but I didn't hear too much about it.

Before dinner, I helped my mother-in-law pack. She's going in for private placement, which under this would not have been possible, in Toronto, where most of her family is. About now she's getting ready for bed and she's going

to say good night to her husband, and this is the last time in the lives of either one of them that they will ever say good night to each other. In all likelihood, on Thursday at the nursing home, she will be assessed and promptly admitted. There will at least be family.

It's the lesser of many evils, because it's almost virtually impossible to put a couple who have been married 50 years together in the same nursing home or the same facility, without many months' separation, without distance between them, unless their level of care is the same, unless you get lucky.

So I'm doing to my mother-in-law what to me is my worst nightmare between my husband and myself. I don't know how else to deal with it. I didn't want to get quite so emotional, but after 9:30 tomorrow morning, they'll never see each other again. There's nothing that accommodates couples.

We had managed to postpone this inevitable end by almost a year. When poorly supervised in their own home, with community care that was never adequately updated, without proper in-home supervision to realize how her health was deteriorating and therefore affecting his, we brought them into our home.

I commend Bill 101 because it does raise the standards generally, I hope, of all nursing homes, because the one that he was to go into direct from hospital was something out of a Charles Dickens novel. It was horrible. The only alternative there, which again would have separated them permanently, was to bring them into our home, which is what we have done.

I will now get to my presentation. I'm here to speak on behalf of the in-home family care givers. I am a care giver of two elderly people, both in deteriorating mental and physical health. I'm in the process of trying to secure appropriate long-term facilities for them both. I'm not here to give an objective overview of the proposed legislation changes. I represent the thousands, and over the next few decades millions, who will be affected by the changes that are proposed, so I'm going to be very subjective.

I see nothing in Bill 101 which suggests that the process I am going through, and many in this room have probably been through, would improve with any of the proposed changes. In fact, what concerns me is that if this bill were in place right now, my options for my in-laws' long-term care would be reduced, possibly with tragic consequences to them and the rest of the family.

My mother-in-law's normal nature is such that with this system she would be forced into a nursing home, probably here, where she has never lived. We had to bring them from Cornwall. She would not necessarily be able to go into a home in Toronto, where all her family is and can visit her, and alone in a strange place, with old people who are sick, this woman could not survive. That's why I'm sending her where there is at least her sister in the same home and family visiting. It's the best we can do.

I had a problem with placement coordinators. As I say, I've had a lot of experience lately with the system and the way it works now. I've been very impressed with a lot of it, and I must say one of the first things I'm impressed with are the people. However, I am currently working through

someone who's called a placement coordinator to find a suitable extended care facility for my father-in-law. This is going through the public system. Her job description is somewhat less than what is suggested in the working paper, Redirection of Long-Term Care and Support Services in Ontario. She does not have the power to refuse placement to my father-in-law. Nursing homes may deny our request for placement if they do not have the ability to meet his needs—I can understand and accept that—but there are other nursing homes which do provide the extended care my in-laws need. There are alternatives and choices.

I'm concerned that the powers bequeathed to this new breed of placement coordinator gives the individual in that position control of the lives and deaths of a few million Ontario residents, and not only the elderly but also their families and friends. He or she holds the only key in this system to access all in-home services and long-term care facilities. I find this prospect scary.

Under Bill 101 there are to be no private placements by which a family or individual in an extreme situation—which can happen almost overnight, in our case two months—can get the facilities they need when they need them. When my in-laws moved in, my mother-in-law appeared to be perfectly normal and healthy—not too bright, but normal and healthy. In the last few months, dementia has reached a point—I won't go into the details, but it's very difficult in the home.

All placements ultimately are to be at the discretion of this all-powerful placement coordinator. Under the proposed new system, my mother-in-law would have been forced into a local facility where she'd know no one. In her normal state of mind, this would have reduced her to a vegetable. She never could deal with large groups of strange people nor make friends. Now, with deteriorating mental faculties, it would kill her very quickly from the stress. From talking to friends whose parents have dementia and Alzheimer, they actually have the same fear even though their parent was probably very bright under normal circumstances.

We have found this alternative route. This would not have allowed us that.

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I can appreciate the thinking behind the intent to bring all facilities and services under one roof, so to speak, but by doing so, you take away alternatives, forcing us all to a single system which cannot meet all the needs that exist when they occur. I appreciate that the standards of nursing homes are to be raised, having visited a number of them and, as I mentioned earlier, saved my father-in-law from one which to be appeared to be something out of the 19th century in Charles Dickens's time.

But please do not close the door on the alternatives of families and individuals. Leave the private route open, and may I suggest it be expanded. The standards of all long-term care facilities can still be raised with what's in the bill. You can do that without closing the door to private options, as it appears is intended by Bill 101.

The appeal process: I couldn't believe it when I read it. Bill 101 creates the concept that an individual can be re-

fused admission to long-term care by this placement coordinator. The appeal process outlined appears to be a release to the problem of the single door, single keyholder. But Bill 101 puts the onus of appeal on the shoulders of those least able to understand or cope with the process, and a lawyer may be needed from the beginning, since further appeals may ultimately go through the Divisional Court. Any mistakes you make trying to represent yourself, you won't make it through the Divisional Court. That's lawyers' territory.

This whole process increases the financial, emotional and physical stress and responsibility on family and friend care givers as well as the individuals themselves. The additional workload of the appeal process would be impossible for care givers such as myself to handle on top of all the other responsibilities, intimate things, that go with caring for my in-laws—and I have a lot of home care, by the way. I can barely keep up with the changes in their needs and the associated doctors' appointments, testing procedures and selecting the appropriate means for the whole family and our staff to meet their fast-changing needs.

I cannot imagine any reasons for which an elderly individual could be turned down, so why there's a need for this I don't understand. And at that point in the life of any individual, the lengthy appeal process outlined—and don't tell me it's short—becomes a joke, a very cruel joke, and to make the individual responsible for initiating such a process shows considerable unconscionable ignorance on the part of those who created this document. They should live in my home for 24 hours.

The thrust of the working paper and the act fail to recognize the fact that many elderly suffer health problems which leave them unable to direct their own care or assess their own needs, much less deal intelligently with a bureaucracy.

As for this concept that people would prefer to stay in their homes longer, I am sure my father-in-law, who has the mental capacity most of the time of a two-year-old, at best a seven- or eight-year-old when he's on a good day, and my mother-in-law, whose mental health currently is that of about a seven-year-old, would tell you gladly they would rather have stayed in their home. I don't know if either one of them would still be alive or in any state of health to enjoy what they have.

Having observed the secrecy which surrounds the current services which offer help under provincial and local funding, such as home care, I rather question if in fact this bill isn't merely to limit the number of people who would dare question the authority of the placement coordinator. You make that appeal process difficult enough and people won't appeal. They're stuck.

While it is the intention of this government to establish an Advocacy Act to act on behalf of seniors who are unable to express their needs or act on their own wishes, the onus remains on the physically and mentally incapable individual to have the presence of mind to know his or her own inabilities and to know how to intelligently seek this avenue of assistance.

My mother-in-law thought I was crazy Saturday night when I tried to quiz her and did not understand why she could not make up her mind which room she was going to sleep in that night. When our support staff went up with her, as she was wandering around the house and finally went up stairs, we could not determine, what is this other room? What is the choice? I was concerned I was going to go to bed, my husband and I, and we'd find her in our bed, or was it our daughter's room? No, it turned out the alternate room was the bathroom, and you want to ask her if she can assess her own needs? You want to put her in the position of a possible appeal? As I say, she's probably maybe a little younger than most people with her mental and physical health but not that much.

You have a policy that's stated very strongly in here which I can't understand that says no new chronic care beds. I'm sure there must be something I'm not understanding here. If there's to be no increase in the number of extended or chronic care beds available in the near future. either under government funding or privately created, this is a contradiction. This is going to force people into a lengthy waiting list, risking that their needs will increase beyond what is available or will be available under inhome services and beyond what a care giver can provide or be reasonably expected to provide in a home setting, long before an appropriate bed becomes available. A bottleneck is very likely to be created which will undermine the whole intent of the working paper, which seems to pay a lot of attention to care givers, but in fact I question that

It is noted in the working paper that, through sheer demographics alone, the number of people in need of chronic beds will increase, reaching a 68% increase just over the next 17 years. That's not that far in advance, and a few of us will be in this category in 17 years. The average age of admission to long-term care facilities is now over 80 years. It wasn't that long ago, I understand, it was only around 70 or 72, and by the way, that information also, the 80 years, comes from the working paper.

With the existing level of in-home support services, with just what's available now, more people are in fact staying in their own homes longer, and therefore the greatest demand now, by the time they are ready to leave their homes, is for extended and chronic care beds.

More often now, requests for beds are emergency situations. I came across this when we were looking for a nursing home a year ago now in Cornwall. The placement coordinator there was just saying: "Look, we're doing our best, but pretty well every placement we now have is an emergency, because people have been able to stay in their homes as long as possible until it's just no longer—and it's now, 'We've got to get them out quickly,' and there are no longer choices. And there are so few beds."

More often now, requests for beds are emergency situations wherein available in-home services, plus the care giver, cannot come close to meeting the minute-by-minute needs of an elderly family member. Such emergency situations can and do literally occur overnight—I think the highest rate of strokes is between something like 5 and 8 in the morning—whether it be a fall, a stroke or even a sudden increase in the progression of a disease or condition, which

is what I face, with my mother-in-law dementia, a very advanced, cruel diabetes with my father-in-law.

That a study is being done to examine the role of chronic care facilities actually seems rather redundant. Why you need it I don't know. The information to put together such a study is actually contained right in here and it's very well known by those already working in this field. You probably will have gathered a lot of that information just from your forum. You've been in a number of cities, I know, and you've probably heard all those problems already.

My last point is actually a summary of what both Bill 101 means and the points that are here as well as a bit of what's here. It makes it very clear that the government's intention with this new direction in long-term care is to place the primary responsibility for care of the elderly square on the shoulders of the family and friends and the elderly individuals themselves, in the guise of this being a good thing and respecting their dignity.

Personally, I'm a former reporter and a federal civil servant in the propaganda end of things and well aware of the trick of governments to publicly announce great intentions under new programs that look and sound great but which in practice actually take back some or most of what was originally there. This bill, with a few exceptions, is one of the most obvious cases of this I have ever seen.

The working paper speaks of increasing in-home support and raising standards in long-term care facilities, but the reality of the current situation shows some possible insecurity on the part of the government. Cutbacks in home care provision and more rigid standards under which home care and associated services can be provided fly directly in opposition to the stated intent of the working paper. Simply, this government is saying one thing and doing the opposite. And because of the amount of home care, I get in on all the grapevines, so I know what's going on.

If this is the case now, I'm very suspicious about the form and restrictions that the regulations, yet to be seen, are going to hold. This really bothers me. To see an act and not know what the regulations are—it is not uncommon, for a number of various reasons, for something to appear in regulations that totally contradicts what's in the act, and unless somebody takes it to court, it never is resolved. I would hate to see that to be the case.

I see Bill 101 as offering what appears to be great promises to individuals and families, yet in fact it's forcing the onus of care on those individuals and on their families, in spite of inappropriate individual circumstances and the inability of some families to respond to the needs of elderly parents and relatives. More families, in spite of their particular circumstances, will be forced to take on the care of elderly relatives for longer periods of time, with no additional beds, than is currently the case.

Few houses are large enough, and here's a very significant pointand you'll say "anecdote." No, it's not. Few homes are large enough or have the bedroom and bathroom facilities on the first floor to accommodate a disabled elderly relative, and certainly not two. We're fortunate; the house we rent did have an addition put on. A laundry room

was turned into a four-piece bath and I gave up my den for my father-in-law. He's on a walker or needs assistance. He can't handle stairs. The one time we did take him up to the second floor, he was sick to his stomach.

I don't know of very many homes which can accommodate someone under those circumstances. You can't take care of an elderly relative in-home unless you have a bathroom on the main floor, and you need a bathtub. Think. Do you know any homes like that? Maybe one in 10.

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Time and privacy for a parent and teenager to be alone and meet the emotional needs of those young adults is gone. Thank God we have done a very good job with our daughter, now 18, that she has been able to withstand this past year. But I know where I've slipped, and she just doesn't complain. Fortunately, our other son is 26 and he's more help. That's good.

More of us adult children care gives are in our forties and our fifties, and in some cases even older. Many of us are single or divorced and raising children and trying to have some life of our own. Thank God I have a wonderful husband myself. I could not have survived this past year without him.

The average family simply cannot adapt to the increase in the intrusion of professionals in the home, however helpful they intend to be. You have to realize that we have, I think, five different care givers who come into our home over the course of the week. We could have but we decided not to have four different other professionals making regular visits into the home. While we have been able to handle the stress of that, of these many strangers coming in and discussing our most personal aspects of our family lives, most people I have spoken to cannot understand how we do that. I guess because we've always had a very good family situation to begin with, we have been able to cope with it. But I have to admit I know many family situations where that kind of intrusion and those strangers asking those questions would just not be.

The first priority, which is what happens when you have the elderly in the home and you have all these professionals come in—it becomes a forced priority of the elderly. This hurts and deprives families of the time and mental space needed to meet the needs of other members of the family. I believe my own daughter's health has been neglected, and I may pay for that. These needs cannot be scheduled to occur only when respite care is available, and by the way, respite care in our case would be totally out of the question. It's just not a practical alternative in many cases.

There's also the increased financial burden on families of the additional costs of heat, hydro and food which is not addressed. At the very time when elderly parents need help, it's so often the same time that middle-aged couples have college- and university-age children also in need of financial assistance to continue their education. Who gets first call on the available funds that middle-aged couples have? Fortunately, that is not our situation, but it is the situation of others I know. In our case, my father-in-law was smart enough to put money aside.

The additional household costs of caring for my inlaws is currently just under \$600 a month. That is compared to the costs for our family of four. I keep everything recorded very well on a computer, so I had all my figures to do my comparison of the year before and the time since. and that has actually gone up from about \$521. I think. Around June I did my first calculations after they'd been in for a while. Their food needs and nutritional needs alone account for most of that \$600, probably about \$400 or \$450. May I add, that does not include the cost of medicines, which are no longer covered by provincial drug plans for seniors—they took that back on us too—nor the cost of the diapers for my incontinent father-in-law, and that runs very high too. I don't have any idea if that's included. Under some home care programs, this could have been provided for, but because we didn't need quite the extent of a certain program, we don't get this covered.

In conclusion, there is nothing wrong with what Bill 101 honestly gives, such as expanding the availability of the kind of care we have been able to access, but there is much morally and practically wrong with what it takes away. It's our right as consumers to have choices and alternatives to meet our particular needs when those needs arise, and I can't see how this offers us very much of that.

The Chair: I'm sure, Ms Cluff, that everyone in the committee wishes that you would not have had to come before the committee. I think, as well, we're indebted to you for coming, because I suspect that there are far too many people in the province and indeed even among the committee members who are experiencing the kind of situation that you are. This was not, I'm sure, an easy thing to do, but we are indebted to you for coming.

We'll begin the questioning with Mr Jackson.

Mr Jackson: Yes, I would agree, Ms Cluff, that your candour and your honesty, your brutal honesty, about the circumstances that you're living under, your ability to convey them to us, is very close to a first for this committee. Having said that, you demand of us to be equally candid and there's a certain integrity that you draw from out of us as a result of that.

On only one previous occasion have I said that all three political—but I feel I must say it now in a tribute to you and your presentation. I have said that all three political parties in this province have foisted on the public a concept of community-based health care which is about a 25-year-old concept born out of circumstances and new wave treatments in Europe, but we have not as politicians changed the optics, we've not changed the language. We've continued to sell this.

Today in Ontario, it's very clear that we have a system that is in contraction and the people will have less access to health care in this province. That's a fact of life; the document says it. But you, perhaps, have made it more clear. I won't ask you a question; your brief is very clear and very poignant. I only wish to say to you that you remind me of a Chinese proverb which says that the true measure of a society is how it cares for its elderly, and you have left that with me, if not other members of this committee. Thank you.

Mrs Cluff: I appreciate that.

The Chair: Before moving to the next question, there is a message here, and because it is an emergency, if there's a Mr Lou Beauchamp in this audience, would he please call home. We're not sure whether this is the appropriate meeting or another, but if there is a Mr Beauchamp here, would you please call home.

Mr Hope: There is another meeting going on next door.

The Chair: Yes, well, they're passing the message in other meeting rooms as well. Given the nature of it, I apologize, but I wanted to just ask if he was here. Ms Caplan.

Mrs Caplan: I think everybody on the committee was moved by your presentation. I want to thank you for coming and sharing your experience with us. I think there are a number of us—I can only speak for myself—who have also experienced the frustration of trying to access appropriate care for parents and in-laws.

One of the things I honestly believe is that the existing system is in need of reform, and that is not only from experience but because I know that in the existing system today, all the wrong incentives apply. With the per diem rate that is in place in nursing homes and homes for the aged, the incentive there is to take in the person who needs the least amount of care, and you therefore often have people for whom a placement would be most appropriate. So the concept of having an assessment by a placement coordinator, I think, is a good concept and—

Mrs Cluff: We do have that, but it's not part of the system.

Mrs Caplan: You do, yes, but not everywhere.

Mrs Cluff: No. More should be done, yes.

Mrs Caplan: That's right, yes. There are parts of the province that do not have that. I see positive results coming from the level-of-care funding which will hopefully address the individual need and allow for choice. But there are a number of parts of this bill that can be improved.

Mrs Cluff: There are parts which I must commend, to be quite honest with you, especially where I mentioned having seen this one nursing home and having spoken with another individual who had seen the same one. He also was almost moved to tears from the same experience in that place. At the same time I've seen fantastic ones, private, public, whatever. But no, there are some excellent parts, both in the bill and this. I'm only pointing out the ones where a person who's drowning is telling you what it's like. This is where I see the weak points. For the most part, for the rest, I have to commend a lot of it.

Mrs Caplan: The other concern that I have, and we've discussed this in the committee, is just this one small part. What's missing are the comprehensive long-term care framework and policies which we've been told will be out in March, we hope, and also the chronic care role study that you referred to as being redundant. In fact, to develop this without that could prove to be a serious error

I want to thank you for coming today. I don't have any questions. I think your frustration and your experience are important for the committee, and I hope the government's heard because it is important to look at the flaws and also at the parts that are missing from this piece of legislation. If it's not going to be addressed here, then I think you and all the families and care givers and all of us potential future clients would hope that those missing pieces will be a part of that framework and chronic role study. For one thing,

The Chair: Mr Wessenger.

Mr Wessenger: Thank you very much for bringing your personal experience. I think too often we just hear more theory or more from service providers. It really brings us back to reality when we hear from someone who does have the responsibility of being a care giver. I think probably all of us here have shared—maybe not to the extent of your experience—with elderly parents or in-laws in that care giving experience and understand the stress that it puts on families.

What we're obviously trying to do is to make a system that puts a priority on those people who have the greatest need for care. We want to ensure that those having the greatest need get the first priority. The only thing I can say to you is that this whole placement coordination system is an attempt to try to ensure that people with the greatest need get the first priority, and one of the advantages of the system is that it isn't limited geographically. In other words, the person assessed in Ottawa has a choice of going anywhere across the province.

Mrs Cluff: I wasn't aware of that. Good.

Mrs Caplan: That's to be defined in regulations. It's not in the legislation.

Mr Wessenger: That's the way it will work, so it will be an advantage. Also, I think it will counter that problem of some facilities preferring to take the lighter load care, and this will ensure that the heavier load care would get first priority. In your instance, I think your two in-laws would certainly have the highest priority in those circumstances.

Mrs Cluff: I can understand to some degree the sort of single gate, the key holder, but when that is combined with no expansion of beds, it's the two put together where I see a bottleneck occurring until such times as new beds are added. There is sort of an overlapping that I can visualize occurring here where, during that time, people will not have the option of private and are stuck on a waiting list.

Mr Wessenger: Perhaps maybe you could say what you mean by "not have the option of private."

Mrs Cluff: For example, the placement for my mother-in-law is not through a placement coordinator. It's not through the public system that's in place at all; it was direct contact with the home. Yes, they had a private room available and were very pleased that it was dear Ethel Rogers's sister, and we made arrangements. We were sent medical material for our doctor to fill out and we've sent that in. Thursday morning at 9:30, a quarter to 10 she goes through psychological and physical checkups and an interview and a nice lunch, and in all likelihood will be unpack-

ing her clothing by late Thursday afternoon. There has been no involvement of any public coordinators or any of the system currently. This is what I mean by private placement.

Mr Wessenger: That's what you mean, without going through the placement coordinator system.

Mrs Cluff: But under this Bill 101, I understand that door would not be in there for us.

Mr Wessenger: As far as long-term care facilities are concerned.

Mrs Cluff: They have extended care there too.

Mr Wessenger: Yes. Perhaps one thing I should make clear is that certainly the government does recognize that there are problems with respect to the distribution of long-term beds throughout the province. There are clear areas that have deficiencies. In fact, my own area is one of those areas that has a high—

Mrs Cluff: What is your area? Mr Wessenger: It's Barrie.

Mrs Cluff: That's what I thought. Hello. I'm formerly from Barrie.

Mr Wessenger: Are you from Barrie?

Mrs Cluff: Yes. My husband, Guy Cluff, was the general manager at the public utilities commission.

Mr Wessenger: All right.

Mrs Cluff: You may remember him.

Mr Wessenger: Yes.

Mrs Cluff: I may have interviewed you, actually, in one election in the late 1970s: I'm not sure.

Mr Wessenger: Yes, I thought the name was so familiar but that's—

Mrs Cluff: That's going back about 13 years.

The Chair: Perhaps on that note we will bring this evening's hearings to a close. Again, we all thank you very much for coming here this evening and sharing your experience with us.

Mrs Cluff: I really appreciate the time you've given me.

The Chair: We wish you the very best for the future.

Mrs Caplan: Your in-laws are very lucky.

The Chair: The committee will stand adjourned until 9 o'clock tomorrow morning.

The committee adjourned at 2125.



Substitutions present / Membres remplaçants présents:

Bisson, Gilles (Cochrane South/-Sud ND) for Mr Drainville

Caplan, Elinor (Oriole L) for Mr Daigeler

Carter, Jenny (Peterborough ND) for Mrs Mathyssen

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mr Jim Wilson

Jamison, Norm (Norfolk ND) for Mr Drainville

Marland, Margaret (Mississauga South/-Sud PC) for Mrs Witmer

Rizzo, Tony (Oakwood ND) for Mr Owens

Wessenger, Paul (Simcoe Centre ND) for Mr Gary Wilson

Also taking part / Autres participants et participantes:

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel:

Gardner, Dr Bob, assistant director, Legislative Research Service Drummond, Alison, research officer, Legislative Research Service

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 24 February 1993

The committee met at 0906 in the Westin Hotel, Ottawa.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. Bonjour à tout le monde. I want to welcome everyone to the morning session, our second meeting here in Ottawa, to review Bill 101, An Act to amend certain Acts concerning Long Term Care. Encore une fois, nous sommes très contents d'être ici pour étudier le projet de loi 101, Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

SISTERS OF CHARITY OF OTTAWA INTEGRATED HEALTH SERVICE

Le Président: Notre premier invité ce matin, M. Michel Bilodeau, services de santé intégrés. Monsieur Bilodeau, vous êtes le bienvenu au comité. Welcome to the committee. Bien sûr, vous pouvez nous parler soit en français ou en anglais, nos deux langues officielles.

Mr Michel Bilodeau: Merci. Alors, mon nom est Michel Bilodeau. Je suis le président-directeur général des Services de santé intégrés des Soeurs de la Charité d'Ottawa. Ma présentation sera en anglais, mais mon texte est disponible en français et en anglais, s'il y a des gens qui le désirent en français.

The Sisters of Charity of Ottawa Integrated Health Service is an organization that has just been created and integrates under a single board of trustees and a single chief executive officer. The four institutions owned and operated by the Sisters of Charity in the Ottawa-Carleton area include: St Vincent Hospital, a 516-bed rehabilitation and continuing care hospital; the Résidence Saint-Louis, a 186-bed charitable home for the aged; the Elisabeth Bruyère Health Centre, a 225-bed rehabilitation, palliative and continuing care hospital, and the Villa Marguerite, a 70-bed nursing home. With more than 1,000 beds, this organization is one of the largest in Canada that provides long-term care.

The government's long-term care redirection in Bill 101 will obviously have a direct and immediate impact on these facilities, particularly on the Villa Marguerite and the Résidence Saint-Louis. Today's presentation will focus on two specific aspects of the bill—the funding of long-term care facilities and the admission process for new residents. Of course, we have a lot of other things to say, but these are the two points that are of greater concern to us. These

points will be looked at from the point of view of how this new legislation is a bureaucratic nightmare.

In an article published on January 10 in the Ottawa Citizen, Mr Robert McLean, who's defined as executive director of Ontario's Premier's Council on Economic Renewal said:

"Each part of the bureaucratic organization has a mandate and operates within a set of rules. Lacking an objective assessment of outcomes, conformity to those rules becomes the measure of performance. This is what bureaucrats call accountability. The typical response to suggestions that we might get more done with fewer rules is that the rules are necessary for accountability to the public. This is false. The rules are all about accountability for inputs—the approvals required for spending. There is almost no accountability for the outputs, or in other words, what that spending achieves."

We wish Mr McLean would work for the Ministry of Health or the Ministry of Community and Social Services. The rules that the government wants to impose on long-term care facilities are a clear illustration of the bureaucratic mind at its best, or rather at its worst. Funding will now ostensibly be divided into three components, one for nursing and personal care, another one for programs and the third one for support services, within which categories transfers of funds would ordinarily not be permitted. Within the first two categories, the money provided by government will actually represent reimbursement of expenses for which very specific standards will apply. There is no provision for generating surpluses within these two categories, which will be permitted only in the third sector pertaining to support services. The authorization to generate surpluses in the latter sector, of course, will apply only if funding is sufficient to make this potential feasible, which is far from obvious.

0910

Ladies and gentlemen, managing a facility requires flexibility. A funding scheme based on reimbursement of costs prevents managers from demonstrating initiative and creativity, limiting them instead to complying with rules. For example, if the actual cost of raw food is reimbursed, as we have seen in draft regulations, the manager will have no incentive to look for suppliers who could provide food at a better cost or to profit from the savings generated by group purchasing.

The Sisters of Charity of Ottawa Integrated Health Service is a 1,000-bed organization which has a purchasing power that could generate savings on raw food purchases. In turn, these savings could be used to improve the programs provided to the residents or even to establish new programs, but this will be forbidden by new regulations.

Here's another example of the negative effect of this lack of flexibility. Let's imagine that a new piece of equipment becomes available on the market that permits, let's

say, baths or transfer of disabled residents with one employee instead of two. With the proposed regulations, the facility would have to use the surplus generated in one area, which is the support services, to buy the new equipment and maybe then face a deficit in this area, but then could not reduce the staff on the other hand to pay for it.

In summary, the proposed regulations are a disincentive to good management and could even translate into poorer quality of services to the clients.

Global funding helps the facility react to the needs of the clientele by using the surplus generated through good management practices to improve existing services or to establish new ones. For example, the two hospitals of the Sisters of Charity of Ottawa Integrated Health Service which currently benefit from global funding have established geriatric rehabilitation programs and respite care programs within their respective chronic care bed allocation. These programs assist elderly persons to remain in the community or return to it, but the Ministry of Health has never recognized these programs for funding. So the two hospitals have used the surplus generated by global funding, by good management, to start these new programs in spite of the fact that they were more costly. If they were submitted to the current regulations that are proposed by the government, we would never have been able to do something like that in response to the needs of the community. That's why we need a form of global funding.

In view of the alarming practical implications of the bureaucratic process and framework proposed by the government for long-term care, we recommend that a global funding formula be developed for long-term care facilities based partially on the type of care required as proposed by government but which will allow the facility more flexibility to organize its programs and services. What we say is, it's okay to base the funding formula on the level of care and other criteria, but then once you transfer this money to the facility, let them manage it according to their needs.

Of course, we recognize that the government does not want facilities from the private sector to make profits at the expense of the quality of life of their residents. None the less, not all facilities are for profit. Moreover, it would be more meaningful to monitor the outcomes rather than the process. We believe the government must ensure that residents of long-term care facilities receive appropriate care and services, that they are well fed and that they have a good quality of life. We do not believe, however, that reimbursing the cost of raw foods, to continue that example, is an appropriate way of monitoring the quality of the meals. The same result could be achieved if the government took steps to verify the quality of the food actually served to the residents through unannounced inspection and client satisfaction surveys.

We acknowledge and support the standards established by the Canadian Council on Health Facilities Accreditation, which will present this afternoon to you, upon which the government intends to rely. The problem stems from the fact that the government now wants at the same time to control expenses line by line as well as outcome, which doesn't make sense. In closing on this topic of funding, we wish to add that the proposed legislation does not address the problem of inequity in taxation. Some categories of not-for-profit long-term care facilities are exempt from the local taxes, some others are not. The St Vincent Hospital, the Elisabeth Bruyère Health Centre and the Résidence Saint-Louis do not pay any municipal, regional or school taxes, but the Villa Marguerite, a not-for-profit nursing home which serves essentially the same clientele, paid close to \$60,000 in taxes last year. We therefore recommend that either all of them don't pay taxes or they all pay taxes and then that this be part of the funding.

The second part talks about the admission process. The proposed legislation says that a facility cannot refuse admission of a client unless a ground for refusal prescribed by the regulations exists. We understand the government wishes to avoid favouritism and discrimination and wants to ensure that access is guaranteed to those who need it the most. We are, however, concerned over what the regulations will consider to be grounds for refusal.

There are several legitimate reasons why a facility would not want to accept a specific candidate, and it is unlikely that the regulation will be able to identify them all or even that the coordinator of admission would be in a position to appreciate the validity or the rationale for refusing admission due to linguistic or cultural factors or based on structural design or staffing considerations. Here are a few examples.

The reason I'm saying we operate in French only—when I say French only, it's not a bilingual institution, it's French, period. All the staff is French. All the residents are either French or operate in French and function in French. There's no bilingual sign, no bilingual documentation inside. Everything is in French.

On the other hand, the Villa Marguerite, our nursing home, while operating in French and English, is mainly French and creates and maintains a French atmosphere and character. This is facilitated by maintaining a majority of French-speaking residents and having a majority of francophones as employees, and we wish to preserve this character. Will the new regulations allow us to maintain in our institutions this French character that we thought was guaranteed under Bill 8 on French language services?

The physical layout of the facility clearly has implications with respect to the type of residents who can be admitted. For example, it may not be possible to accept more than a specific number of wheelchair-bound residents on a particular ward, and the location of the nursing station may not permit the monitoring of more than a specific number of wandering residents. Will such constraints be taken into consideration under a centralized admission process? We feel it will be extremely difficult for a director or coordinator of admission to know all of these specifics.

Even if, in principle, funding will be based on the level of care required, changes in the staffing pattern cannot always be accommodated immediately. A certain number of employees are required to care for a certain number of residents. A rapid increase in the number of heavy cases, for example, may not always permit an immediate adjustment in the staffing level, nor will funding commence immediately.

By contrast, if a sharp and uncontrolled reduction occurs in the average level of care required, it may not be possible to reduce the level of staffing immediately. If you want to attract competent and dedicated staff, you cannot bounce them from one place to another and change their hours of work all the time.

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Also, these people get specialized. At the Résidence Saint-Louis, for example, we have a unit specialized for demented patients. We have another specialized for people who have heavy physical requirements. If we cannot control who comes in, then we lack that specialization of the staff.

Will the new regulations allow the facility to refuse admissions on such grounds without having to face a very bureaucratic appeal process as provided in the bill, or will facilities be given the right to appeal? Right now, it doesn't seem they are given that right.

In summary, the bureaucratic and punitive approach of the proposed legislation, and of the draft regulations that have emerged to date, leads us to believe that the facilities could lose the flexibility fundamental to efficient operations. Since funding will be largely associated with the level of care required, we believe that this will create an incentive strong enough for the facilities to admit heavier and more complex cases. Potentially, some facilities will wish to specialize in lighter care, which should be their choice, and their funding will reflect that choice. However, other settings may wish to specialize in handling heavier care because they're better at that and more efficient, and there's nothing wrong with that. This should be encouraged.

Instead of legislating the obligation of facilities to accept all the residents referred by the coordinator, the law should provide for exceptions. Facilities could be authorized to deny admissions based on their own constraints and priorities. However, the coordinator should have the option of compelling admission of a resident against the will of a facility in instances where the personal circumstances of the prospective resident warrant admission on an urgent basis or would face an excessive waiting period.

Another important point is that the proposed legislation seems to have forgotten the right of the consumer to select the institution of his choice. This was a key feature of the government's long-term care redirection published in the fall of 1991.

In closing, I wish once again to quote Robert McLean's article: "Government should be a catalyst. It should mobilize private resources to accomplish public objectives...government should seek to empower communities rather than serve them...competition in public service has the same effect as competition everywhere else: quality gets better and costs go down...we need results-oriented government, which means funding outcomes, not inputs."

The Sisters of Charity of Ottawa have been providing health care in Ontario since 1845, long before governments started to be interested in this field. For the sisters, it's a work of charity and compassion that they intend to continue. We ask and recommend that the services provided by the sisters, and by the other long-term care providers, be judged on the merit of the results achieved; that is, on

the basis of the quality of care and the quality of life of their residents rather than on the counterproductive basis of an organization's degree of compliance with bureaucratic regulations which are not tied to the outcome and complicate the management. Thank you very much.

The Chair: Thank you, merci, for your presentation and we'll go straight to questions and begin with Ms Caplan.

Mrs Elinor Caplan (Oriole): Thank you for an excellent brief with many excellent recommendations. I particularly like the bottom line, which I agree with and have been discussing at some length at this committee over the time that I've been here, and that is that the basis of quality of care and quality of life is not tied to compliance with bureaucratic regulations, but in fact results-oriented output measures of total quality management and continuous improvement as a value would produce better results and more cost-effective results.

The question is how this legislation can be changed to do that. I think there are some suggestions here. Some of the concerns that we have with this legislation as well are that it's just really one part of the whole picture, but you focused on two things that we've been hearing repeatedly. One is lack of flexibility and lack of choice.

The lack of flexibility and the lack of choice are both for the institutions and for the consumers. You've been very clear in how you would see some of those amendments that would allow for greater flexibility, but what I'd like to hear from you is, if this legislation were to permit global budgeting for the institutions, can you think of the other change that would have to happen to ensure outcome accountability without the big stick and the tone of a punitive enforcement model, which we all know in the modern world doesn't work

Mr Bilodeau: I have of course no easy solution, but I think that first of all, all facilities should be asked to require accreditation from the Canadian Council on Health Facilities Accreditation. Our four facilities have a three-year accreditation right now and that brings people to work very hard to comply with outcome standards. That's the first step.

Second, I must say that my experience with nursing homes—we have a nursing home—is that the inspection process so far has been fairly good. We have inspections three times a year. They come and try to work with us at improving the situation, and I've never heard a threat of saying, "If you don't do that next week, you're going to lose beds. We are going to stop admissions," and things like that. It's more saying: "Wee see what type of snacks you give to the patients. Don't you think you should have more fresh fruits and things like that?" So we do these types of things, but it's an approach of helping us, instead of an approach of saying: "Hey, listen. If you don't do that, we cut funding next week." That's what worries me with the approach that I've seen in the manual.

Of course there's a big difference between the legislation and the regulations that come afterwards, and I must say that the legislation usually shows a lot of goodwill, but when you see the regulations, that's when you really face the problem and I'm more concerned with the regulations than the legislation.

Mrs Caplan: If there was an amendment to this legislation, and we've discussed it here before, that required accreditation on the basis of outcome, not just management, that required a quality management program within the institution which the ministry could then support through the kind of compliance approach of the change that occurred, I think it was about 1988, and that a residents' council was also a requirement, do you feel, provided institutions were able to comply with those three and if that was mandated by legislation, that there would be sufficient outcome accountability that would then permit things such as global budgeting or exemption from the kind of punitive enforcement model that is even suggested by this legislation?

Mr Bilodeau: On one hand, I'd be tempted to say yes, but on the other hand, I feel that it may not be exactly enough in the sense that if you have accreditation every three years, a lot of things can happen in three years. So I think, yes, recourse to accreditation should be mandatory and the report should go to the ministry, but at the same time there should be some kind of inspection mechanism in the meantime, once a year or something like that.

In fact, I'm not dissatisfied with what we have now. I'm just concerned about what is proposed with the approach that they have. Someone from, let's say, the nursing homes branch right now comes once a year to look at how we serve the patients, what type of food they have, how the quality of life is. I have no trouble with that; they're welcome.

I have a problem if they will tell me, "Oh, you spent \$5 less on raw food that you should have had and so, because of that, we'll deny you admission next week." That's totally ridiculous. Let's check whether the food is good or not. If the food is not good, we have a problem that needs to be corrected. If the food is good, whether I pay 50 cents for the carrots or 45 cents is totally irrelevant.

0930

Mrs Caplan: What if you included in that proposal the requirement of client satisfaction surveys of both the residents and their families on a regular basis?

Mr Bilodeau: Absolutely. We've been doing that for years and I think it should be mandatory. I have no problem with that.

Mrs Caplan: If that became part of the overall accountability, so it wasn't just checking off an accreditation standard—and there was no requirement for residents' councils in the legislation nor for client satisfaction surveys—you'd be quite comfortable with an amendment that did that?

Mr Bilodeau: Absolutely. We have residents' councils. At our board we're creating a community advisory committee with representatives from the families and the residents and they will elect their own chair and have a seat on our board. So we are quite comfortable with everything that relates to residents' councils, satisfaction surveys and all that.

Mrs Caplan: There are two other amendments that I'm going to wrap into one question and ask you to respond to because the Chairman is already telling me to be short.

One is an amendment that would permit the institution the right to refuse on the basis that it could not provide appropriate care, the appropriate care could then be defined by regulation and you would then allow an appeal mechanism; and secondly, a statement of basic principles upon which the placement coordinator and the framework of the legislation would be based which would guard, or at least clearly state, linguistic, social, multicultural, cultural in general. Would you support those kinds of inclusions in the bill?

Mr Bilodeau: Sure. Yes, absolutely.

Mrs Caplan: Any comment on how those could be framed that would give you comfort?

Mr Bilodeau: I think what I said in my brief is that I feel that generally speaking these aspects should be reasonable grounds for refusal. But then the coordinator of admissions should have a right in exceptional cases to make sure that someone doesn't stay on the waiting list for years, and that if someone is refused everywhere and cannot have access, then he should have the right, but based on exception, not the general rule.

The Chair: Thank you. Mr Jackson.

Mr Cameron Jackson (Burlington South): Michel, thank you for your presentation. I very much appreciate you referencing on page 3 the concept of the inequity of local taxes. A comparable facility in Sault Ste Marie made a presentation in Sudbury, and I've asked that this matter be researched.

If I may, Mr Chairman, for the record, request that some contact be made with the NDP so-called Fair Tax Commission to determine if this matter ever came to light or was ever discussed by the appropriate subcommittee. I'd like to add that to the three questions I raised within that bundle of an inquiry, and if we're to be given some briefing on whether or not this is being looked at because—

The Chair: I'll just note for the record that through legislative research we will do that.

Mr Jackson: Thank you. I thank you for raising that because we've seen the home in Sault Ste Marie had a \$100,000 operating deficit and its taxes were \$85,000 a year.

Mr Bilodeau: I'm sure you will support our private members' bill for Villa Marguerite this spring when Mr Grandmaître brings it then, thank you.

Mr Jackson: No problem. I'd be pleased to assist.

I appreciate the way you've given us a fresh look at the funding and its implications to your need for flexibility and to break down the three categories very clearly and how you're boxed in. That is helpful to us in terms of understanding some of the traps in this legislation, but I want to move to the one that concerns me the most and that is on the issue of admissions and appeals.

There are people who cynically believe that the government is in the process of redistributing the current inequities of placement of individuals in this province, that through growing acuity and lack of mobility, as we empty

our bed-blockers out of hospitals, they're going into these kinds of facilities. There are some who even go so far as to suggest that the government will not relinquish its control of being able to have absolute control over where people will go and where it can block them from being removed from, which is probably a really key point here, that it can block the removal or the departure of a resident from one facility.

Given that this is the case, I don't want you to debate that but let's just presume for a moment that's the direction we're going in, then this discussion shouldn't spend too much time on appeals if we're not going to have it, but rather the concept of overbedding and the kinds of horse-trading and the negotiations that occur between placement coordinators, facilities and government funding.

I'm asking you to look at living with this legislation as it is, because frankly, I sense that's what we're going to have to do. I'm not a member of the governing party. I'd like to see it amended, but they control the total number of votes and ultimately they'll decide what the final look of this will be.

If you put your mind around the concept of overbedding and their discretion to provide additional funds if you're forced to accept someone who has higher-end needs, when you skew your Alberta classification system and you find in that sweepstakes you do poorly, can you talk to the committee about how it will be to operate a facility in that environment where you're actually competing with other facilities to fiscally survive?

Mr Bilodeau: First of all, I must say I have a tendency to believe that people, both in facilities and government, wish to do the best thing. I don't think there's any plot or cynical approach, I just think they're misguided. That's different

Mr Jackson: I don't mean to interrupt you, but the document clearly states that we're going to do all of this without any increase in chronic care beds in this province. So you're looking at a contracting system with a growing acuity rate and controls. I'm respecting the insights you've shared in your brief and I respect your optimism, but frankly, in the eight or so years that I've been working with the Nursing Homes Act, I have a rather more cynical view of things. We just heard last night that a 100-bed licence may disappear from the Ottawa region. Those people have to go somewhere. Those are the kinds of emergencies this legislation anticipates being able to react to, and you won't be able to.

Mr Bilodeau: Let me say first, in this case there are also more than 200 acute care beds closed in this region. You could relocate these people, not necessarily outside of the region but you could reopen some of these beds and place them there, which will be far from ideal, but you can have reorganization and you will have a restructuring of the beds in any region because of closure in acute care.

I must say that for the facilities themselves, what you raise is not likely to be a big problem. The problem will be for those who cannot get in the facilities. I think you're right in saying that the freeze in long-term care beds may have a dramatic impact. The idea that people should stay

in the community is fantastic, but the reality is they have nowhere to go. Families are not there any more. People have one or two children, these children are all over the place and there's nobody to take care of them. In an ideal world, I would take care of my own mother, but she lives in Quebec City and I'm here, so I won't. That's the reality of things.

Will government take residents from one place and force them to go to another? I would doubt that this will happen. What I think will happen is that they'll have no place to go in this region. They'll eventually settle for something, be on a waiting list to come here, and that will take years. So there will be tradeoffs from the waiting list.

I'm not very keen on the disaster scenario. I think it will be problematic. The placement coordination services have been, in this region, rather good at coordinating placement and taking care of everyone's interest. I think though, as the bottleneck increases because of lack of beds—the district health council thinks this region will need more than 800 long-term care beds in the next five years just because of the aging of the population—we may face the same situation that we faced with psychiatric patients 15 years ago. That's a great concern.

What all the reform doesn't take into consideration is that one of the main problems of the elderly is solitude. Living in their homes is often the worst place for them because they're all alone. We should recognize that. Certainly, those of us who work in this field are concerned about the fact that the government seems to think that elderly abuse happens mainly in institutions. In fact, it happens mainly at home, and accidents happen there too.

We feel there is a danger. I don't predict catastrophies. I think there is a danger that if we don't react fast enough there will be a long list of people who will be less well than they are now. Whether in fact we're going to have a dictatorship that will bring people from one place to another, I doubt this will happen, quite frankly. I think at the local level people who work in this field all know one another, and a director of admission who would act that way could not survive. The region would rise and stop him or her from doing that.

0940

Mr Paul Wessenger (Simcoe Centre): Thank you very much for your presentation. I'd just like to explore a couple of items with you.

One issue that's often been raised is the whole question of social needs for congregate living. It would seem to me that having adequate support of housing options would solve that social need for many elderly people and also provide the light care that's needed. Do you see that as very much an important part and a way to relieve the problems of long-term care facilities?

Mr Bilodeau: Yes, certainly. I think it is certainly an approach that will help the elderly face the solitude problem I just mentioned, certainly an approach where cost is lower.

For those of us in facilities, we are not looking for more clients. In fact, we have quite enough. Our occupancy rate is already full. We have a waiting list of two and a half years in our hospitals. We would very much welcome more initiatives to bring people to live in small groups in the community. I think it's an avenue that needs funding and needs help as much as possible.

What we say, though, is that with the rapid increase in the aging population, we do not believe this will replace long-term care institutions. We just believe it will help us limit the growth in the number of beds. So if there's an investment to make, it's quite likely better for government to invest in that type of project than to invest in a large, large number of increased beds.

What we say also is that it will be a little naïve to think that you can just take huge amounts of money from one place and transfer them to the other, or that you can totally freeze the number of beds. It will be impossible. The number of elderly is growing too fast.

How do we do it all at the same time? I have no answer. That's why I don't go into politics. But certainly, I think this is a good avenue of solution that should be part of the global approach to helping the elderly in the future.

Mr Wessenger: I think we'd all admit that global funding approaches on their own do create problems of certain programs not being adequately developed. I'd particularly refer to quality of life programs, which I think are extremely important to have. If you had a different funding model, how would you ensure that such programs like quality of life programs could be ensured in the long-term care facilities? Could you elaborate on that?

Mr Bilodeau: First of all, as I mentioned, I think how funding will be arrived at should take into consideration the weight of the residents; a mechanism, whether the Alberta classification system or another one, to evaluate the personal needs of the patients; then some kind of funding criteria on how much we spend for quality of life activities, and then some type of criteria for how much we spend on building and support services. What I say is, once you have established this, then let us organize it and have criteria such as the criteria of the CCHFA to evaluate the quality of life.

We were just accredited two weeks ago at the Elisabeth Bruyère Health Centre. When they came, they said, "Oh, you have so many recreologists but you have less social workers." So that's a choice we made. We traded social workers for recreologists because we insist more on that type of activity. That should be part of each facility's approach and personality and type of care. I think the council of accreditation has a number of criteria for quality of life, and if you have a satisfaction survey, if you have a good residents' council and family involvement, you'll be able to do it and to control the quality of life.

There's no magic solution, once again, but if you control the amount of money you spend on each activity—for example, how does someone know outside of the facility that it's better to have two more recreologists and two less social workers. What we say is, let us decide that with the residents.

Mr Wessenger: Yes. I just might add, there are really only three categories, as I've said—nursing care, personal

care and quality of life programs. So you do have that flexibility.

Mr Bilodeau: This one we do.

The Chair: Thank you very much. There are many more questions, I know, but unfortunately I'm going to have to close.

Mr Bilodeau: I'll be back this afternoon with OHA.

The Chair: Very good. Merci d'être venu.

REGIONAL MUNICIPALITY OF OTTAWA-CARLETON

The Chair: I would then call our next presenters, representatives from the Regional Municipality of Ottawa-Carleton. Would you be good enough to come forward. The Chair would like to recognize another chair but a more important one, the regional chair of Ottawa-Carleton. Peter, it's very good of you to come down with your colleagues and join us this morning.

Mr Peter Clark: Mon cher Charles, and I owe the title of being chair to my friend Yvonne. Randy, good to see you.

Mr Randy R. Hope (Chatham-Kent): Good to see you.

Mr Clark: And Noble and Madam Minister—oh, excuse me.

The Chair: Flattery is always wonderful.

Mr Noble Villeneuve (S-D-G & East Grenville): It will get you everything.

The Chair: Would you be good enough just to introduce your colleagues and then please go ahead.

Mr Clark: I fully intend to. I have my colleague who chairs our homes for the aged committee management, Guy Cousineau, mayor of Vanier. I have my chief administrative officer, Merv Beckstead, and I have Garry Armstrong, who is the commissioner for the homes for the aged.

I have listened with some interest to Michel. I have a brief that I will present to you. You'll get a package of them, and then we will hope to have a few minutes where we can perhaps have some discussion.

I thank you for the opportunity. We have a formal brief which addresses four areas: funding, access to facilities, accountability and integrated planning. There's a booklet in there about the care and services provided in our homes and a map of the region which identifies the location of facilities and the 65-plus population by municipality.

The region is supportive of the basic principles of redirection: integration of long-term care, health and social services—this covers, in our view, some of the gaps—improved access to quality services and funding equity across the province—also very worthwhile principles—creation of community alternatives to institutions; greater consumer choice or participation, and promotion of racial equity and cultural sensitivity. I think those are all valid and worthwhile objectives.

The region plays a major role in the planning and delivery of health and social services in Ottawa-Carleton and wants the system to be responsive to the community's need, sensitive to ethnic and cultural diversity, fiscally responsible and built through partnerships among public, community and private sectors.

We operate three homes for the aged—607 beds—community support programs and linkages with community college and university education programs. The homes employ close to 900 full and part-time people. We had 470 volunteers coming in from the community to help our residents in 1992.

Until 1989, the region paid about 15% of the operating cost of the homes. In 1989, the regional share jumped to 30% when capping was imposed. Regional council was prepared to live with the increase on a temporary basis until long-term care reform, as it was then called, was implemented.

The government had made a commitment to fund care to the level of need, because what we were experiencing was essentially a larger and larger medical component. The average age of people who were being housed in the homes was growing rapidly. I'm sure you've found that in your travels. We anticipated that when the government's commitment was met, we would see a return to a reasonable level of funding.

0950

I would point out to you that the proposed funding level is flawed. It's driven by available funds, not by consumer need. Strange for a politician to tell you that, but the truth of the matter is that those constraints exist for all of us.

Funding will be based on an assessment system that was not adequately tested, and therefore it cannot be seen to be accurate and impartial. I'll talk to that a little more on some other things that I may want to share with you. Initial funding will be based on assessments conducted last fall, using data that probably is out of date. The turnover in our home since October 1992 is 71 residents; that's more than 10%. In the course of a year it may be as high as one third of our residents, in terms of turnover.

The funding formula proposes to raise \$150 million from increased resident user fees. Our position, supported by the Ontario Nursing Home Association and homes for the aged, is that \$60 million is a more reasonable figure to anticipate. So where's the other \$90 million coming from?

The revised resident copayment is based on an income test only. It ignores the fact that many seniors have assets and desire to contribute to their living arrangement costs. This copayment also, because of that, increases the taxpayer's burden for those seniors who are asset-rich but income-poor. It assumes, as well, that municipal contributions will continue at current rates. We do not accept this assumption.

There's no legal reason why we should operate chronic care hospitals without proper funding, make no bones about that. We urge the government to revisit the funding proposal and consult consumers and providers about the basic assumptions. If there's no change in the funding arrangement, we're going to have to consider what we would call unpalatable options: Cut programs, close beds, lay off staff, perhaps close one or more of the homes; this, at a time when waiting lists are growing and the population is aging. I'll have more on that later. No one's looking

forward to making these tough choices, but if forced, we'll make them

The placement coordination service is doing a good job in coordinating access to long-term care facilities in Ottawa-Carleton. It's funded by the province, it has a community board, and while the system may need some fine-tuning, for the most part we believe it's serving clients and facilities well. It's been doing a good job for many years.

The placement system proposed in Bill 101 is a night-mare. It appears to reduce consumer choice and impose rigid eligibility criteria which could see spouses separated when one meets criteria and the other doesn't. It would deny regional council and the committee of management the right to define the mission of the homes. It would deny the homes the ability to maintain culturally and linguistically unique units and facilities; par exemple, le Centre d'Accueil Champlain.

Le Centre d'Accueil Champlain est un foyer francophone, dont la mission est d'offrir un milieu culturel et linguistique franco-ontarien aux personnes âgées de langue française. De forts liens le rattachent à la collectivité de Vanier, et il fait partie de la famille de Vanier. Nous ne voulons pas perdre cette identité et cette relation, qui ont tellement d'importance pour les résidents et leurs familles.

It would lead homes into the admittance of individuals whose needs are not compatible with those who are already there. In other words, to reduce the average care component, we'll bring in a lot younger people. You're well aware that this is a problem.

The residents of our homes are vulnerable. Quite clearly, their sense of security, their sense of comfort, their real comfort, can be threatened by admitting more mobile, younger people with different interests, different needs. We've developed an expertise in geriatric care and feel that if again pushed to have to redress the balance to a lower medical care component, there would be a major effort to prepare staff and the homes for dealing with a new type of clientele.

We have a system, today, that works, for consumers and providers. Why impose a new and costly bureaucracy? Why not build on what we have and let the community decide what it needs to meet provincial objectives? Our homes have an excellent reputation in this community. It's been developed over many years. We've adapted our facilities, designed programs, educated staff. We do provide quality geriatric care, and we're concerned about the impact on the younger clients and the residents we presently advocate for if we're not allowed to define our admission policy.

We don't have a health care dollar to waste if this province is to get costs under control. We don't understand why the province is planning to put in place an expensive inspection system to ensure accountability in municipal homes for the aged where a proven system already exists. The Ottawa-Carleton homes are publicly accountable through the the committee of management, executive committee and regional council. They are advised by public appointees who are members of the committee of management advisory committee. They are accountable to the programs supervisor. And we have consistently received

three-year awards from the Canadian Council on Health Facilities Accreditation. It ain't broke.

We urge the committee to recommend that the government build and strengthen the existing system, not ignore it. If you want to build a quality system, look at bringing other homes up to our standard, not bringing us down to the lowest common denominator.

I want to briefly touch on an area not directly related to Bill 101, but important to the successful restructuring of the health care system. We don't believe any single part of this system can be looked at in isolation. We urge the government to look at the big picture when it's making decisions and to consider impact on the whole system when it's making changes.

For example, fewer acute care beds means that the percentage of inappropriate beds in our acute care institutions will increase because there's a certain inflexibility in those beds. Therefore, that's going to end up in longer waiting lists for acute care. Fewer institutional long-term care beds in an area like Ottawa-Carleton, which is already underserved, will result in greater demand for home care, 24-hour respite care and supportive services. The chronic care hospital role will change to specialized care, resulting in ever heavier cases.

I just see the snowball rolling down the hill here, and it really bothers me a little bit that we can't sort of create some doubt in your minds that you're going down the right path.

It's important to note that chronic care hospital per diems are significantly higher than our homes, for essentially the same consumer group. There's not a big difference today between homes for the aged clients and chronic care hospital clients because of the demographic shifts.

A failure to provide supportive housing options will result in individuals seeking more costly and intrusive services than they really need in order to live independently. We're already seeing these impacts here. We recommend that the committee ask the government to consider all aspects of long-term care, including health, social services and housing, when making these decisions for the short and long term. It's only by taking a comprehensive approach that we can achieve a rational, responsive, cost-effective system.

In summary, the region asks the committee to consider how to improve the funding arrangement to ensure it funds to needed levels of care; how to return the municipal share to 15%, the historical level; how to build on the strengths of existing access systems such as the Ottawa-Carleton Placement Coordination Service; how to recognize and build on the public and community accountability system in place for the homes for the aged; and, how to develop integrated planning and implementation of health, social and housing policy at the provincial and local levels. We're prepared to work with the government on all these issues.

The region is proud of the responsiveness and innovation in our homes for the aged. We're very conscious of the trust that the residents and families have placed in us to deliver quality care. We want to be able to continue. However, we have an obligation to the citizens of Ottawa-Carleton to use their property taxes wisely and

appropriately. Health care is not a municipal responsibility. We want to work with the government to find a fair and reasonable way to return the region's contribution to an appropriate level, while maintaining quality programs for our residents.

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In so far as it might be useful to have the perspective of why we feel it's important for linguistic, I would ask Mayor Cousineau to talk a little bit about Centre d'Accueil Champlain and how that is of value and need in this community and is being met.

Mr Guy Cousineau: Mr Chair, members of the committee, Centre d'Accueil Champlain is one of only two wholly francophone facilities in Ottawa-Carleton. There are 54 francophones waiting for placement in a long-term care facility in Ottawa-Carleton. The wait can be up to one year.

The district health council reports a shortage of services for the French-speaking elderly of the region. The region has a plan to expand Centre d'Accueil Champlain by adding 44 beds that are out of service. The 44 beds were removed from Island Lodge to reduce overcrowding and improve the quality of life of residents there. Unfortunately, we have been unable to proceed with the Champlain project due to the lack of capital funding from the province.

Centre d'Accueil Champlain is a unique home. It is supported by the Vanier community and provides a home-like, familiar milieu for Franco-Ontarians. We ask the committee to recommend to the government that it make capital funds available to meet the needs of the French-speaking elderly in this community.

Mr Clark: Just at the risk of overdoing this, taking up some of your question time, a demographic forecast of this community: In 1991, there were approximately 72,000 people over the age of 65 in this community. It's predicted that by 2001 to go to 90,000 and by 2011 to go to 114,000. More dramatically, though, for people 80 and up, it's going to go from 14,000 to 24,000 to 31,000, and that's the age category we're talking about. The growth in those cohorts is phenomenal and it's projected to actually be accelerating over the next 20 years. In other words, the problem is going to get larger and it's going to make it even more critical than I know you sense. You wouldn't be spending your time going around the province if you didn't believe it was critical. So anyway, anything you'd like to elaborate on or have us elaborate on?

The Chair: Thank you very much. Your reference to a snowball earlier, I think the committee feels that it's been either in front of or behind a number of snowballs as we've travelled around this past week. So we will try to deal with snowballs and we'll therefore begin the questioning with M. Villeneuve.

Mr Villeneuve: Peter, thank you very much, with your group this morning. Your population democraphics are most interesting. You tell us 607 beds are available, and I know I have some people within the constituency that I represent who are on the waiting list.

Centre d'Accueil Champlain has a list of 54 immediately ready to occupy a bed, if indeed it were available. Would you know, Peter, how many are on the waiting list of the other-

Mr Clark: Garry.

Mr Garry Armstrong: Probably an active waiting list of about 150, but because of the existing situation and shortage of beds, we try to maintain it at a reasonable level. Our turnover is about 100; so we work with about 150 regularly. If we opened it up through the PCS, we could fill 300 without a problem.

Mr Villeneuve: Those are interesting statistics and certainly I think Peter and you people have sounded an alarm here; 607 beds are presently available. It certainly sounds like that number is going to diminish, Peter. Could you comment on that? Just how do you foresee it in the next year and a half, two years?

Mr Clark: We have a relatively old and inefficient facility in Island Lodge. There's been some talk about perhaps building a new one, but there is no particular reason that we're now spending \$6 million or \$7 million of the local taxpayers' money in addition to what our share was in 1989. Frankly, I don't intend to continue to do that. So the answer is yes, we'll just close Island Lodge or a good part of it as a way to eliminate the problem.

We're in a situation where more and more of our customers have dementia. It requires specialized care; it requires a lot more tolerance than the current funding arrangements for the homes for the aged supply. So while we're doing what we consider to be more than our share at the moment, we don't see anything in this bill that's going to resolve some of the problems. We've raised that. Frankly, by just freezing entry and not taking on any more, we can close 100 beds in the next 12 months and 100 beds in the 12 months after that, and eventually, because of the inadequacy of this particular facility, reduce the number of homes we have by probably 50%.

Mr Villeneuve: You see no one picking up the slack?

Mr Clark: I certainly don't see any encouragement anywhere, and since it is really a provincial government responsibility, I see no particular reason for me to continue to shoulder it

Mr Gilles Bisson (Cochrane South): You talk about Ottawa as one of the areas in the province where there is already a model of the placement coordinator in place. How does that work? I have an understanding, but just from you, because you're in the business directly. But the thing I'm really interested in is the question of appeals. If somebody is not happy with the decision, do you have any kind of an appeals process in place for the resident or the future resident or the home?

Mr Clark: Yes, I think there is a whole system in place. It's a fairly complete system, Gilles. Historically, my connection with the PCS has been as a member of the district health council and sort of peripheral, and you'll probably get some detail from Garry about that. But I think you may well later on get some, if you really want it, from Billy Dare, who is the former chair of the thing.

Mr Bisson: If Billy is there, could Billy put his hand up? Okay, now I know who it is. Thank you.

Mr Clark: She'll be in front of you later today. But I think what we'll do is ask Garry to give you an outline, and if that's not enough, we'll have something put together to send you independent of this.

Mr Armstrong: I have in fact served as president of the placement coordination service and as a member of the board for many years. One of the keys to the Ottawa-Carleton area has been, and I think Michel spoke to it a bit earlier, the sense of community that we have. Even just looking around at the people in this room, we can probably set up a meeting of the continuing care board of the district health council or the council on aging just using the people here. We seem to work very closely together.

As a community, we decided some years ago that the traditional approach to waiting lists wasn't working, and I think the chair referred to tradeoffs etc between institutions, and we agreed as a community to establish a system of a cooperative board whereby we would all establish and utilize the same admission forms for chronic care hospitals, nursing homes and homes for the aged. We spent many years developing that.

We also developed the centralized waiting list, so that when people asked Ottawa-Carleton, "How many people on the waiting list?" we didn't add up all of the institutions and come up with 20,000 when we knew there were about 3,000. So our waiting list is fairly factual, which is a real key issue, and the system has worked strictly on a cooperative basis. We have agreed not to accept individuals into our institutions without going through the PCS process and utilizing those forms. One of the problems we're facing now with shortages of beds, however, is that people are very quickly starting to look at other options, so I'm very supportive of a placement model.

I think the question with respect to appeals is a good one. Indeed, under our process, the individual is encouraged. In fact, through the council on aging, we have developed ways of going to institutions, and we encourage visits, and the individual makes that choice. The placement service helps them in terms of determining whether the institution they have chosen is in fact appropriate to their needs. The assessment is then done and referred to the institution, at which time the institution deals with the client and the placement officer. At that time, the decision can be made in terms of the appropriateness. Finally, there are waiting lists in every institution, and as a result, the individual then becomes very aware of how long it may take, and the decision through the placement service then can be made for an interim placement. So that aspect works quite well.

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The key, I think, that Michel referred to earlier had to do with the interim placements, and unfortunately what we're seeing with the shortage of beds is that many of those interim placements now are being made by necessity outside of our community.

Mrs Yvonne O'Neill (Ottawa-Rideau): Gentlemen, you can be very proud of your brief. You've said quite a bit with quite a few words, but I think that's kind of characteristic.

Mr Villeneuve: That's a low blow, Peter.

Mr Clark: That's okay. I'll get even.

Mrs O'Neill: I am very pleased that you mentioned the placement coordination. You've just had a chance to explain that. We've had some very good reinforcement that there are many good systems across the province, and they should be recognized. The municipalities have come forward, and not in the numbers I would have wished, but I'm very pleased that you have. You've also reminded us of the level of accountability that's in existence at the present time, and I don't think that should be overlooked. You reminded us, too, that these facilities we're looking at now have already got mission statements; they have commitments to their communities. We're not starting from scratch

Another thing that I'm pleased you mentioned, and I'm surprised it isn't mentioned in more briefs, is the effect that some of these new regulations seem to impose on spousal relationships, on familial relationships, and I think we have to be very conscious of that as we proceed to put some things in writing on this piece of legislation.

I am happy, too, that you talked about the series of appeals in recommendation 3—appeals that we hadn't heard of in my recollection of our hearings to this date—the facilities being able to appeal the monitoring and sanctioning decisions and the right of the governing bodies to determine the mission, as I stated earlier. That's new, I think, if I recollect correctly.

I'd like you to please expand on two of your recommendations if you could. The frequent assessment process is certainly a concern of mine and of others, that we're only going to be taking a picture on an annual basis, a snapshot picture. Your figures of a one-third annual turnover are rather frightening. I didn't think they would be that high. Could you say a little bit more about the end of that recommendation 1, "should take into account regional differences and special circumstances," just expand on that? In number 5, I wanted you to talk a little bit more about how you feel the support of housing sector integration could be highlighted better or take place more directly in this legislation.

I could ask a lot of questions. You have told us that you want to put doubts in our minds, and I think you've challenged us regarding the need for change. I'd just like you to expand on a couple of those points you've made.

Mr Clark: To be honest, we accept the need for change. We think that something has to be done. It's more a question that we think it needs to be done a little bit more collaboratively than this appears to.

I guess the assessment process, because of fairly high turnover and because of trending—and we clearly are trending to more and more of a care component—has been pretty consistent. So if you're assessed in October and that assessment is used six months later to determine your level of funding, we're already at an 18-month gap by the end of that funding year, and with that much turnover, there could be a considerable difference in terms of the care component.

So the option is, if you're not funded to the appropriate level of care, that the residents won't get it. They may need

it, but because your funding is a year and a half old and based on a different population and a different mix, it would mean that we would have to start to discriminate against clients in order to be able to meet the care needs; in other words, try to keep the mix at where it was even though we already know that the mix is going to shift towards more care. Having said that, it would put us in a position of forcing certain things that, in my mind, would be wrong. Garry, do you want to expand on that a little if I haven't understood it properly?

Mrs O'Neill: Is that what you mean by special circumstances and regional differences? I guess that's the part that I think is new to this presentation in your recommendation 1.

Mr Armstrong: Certainly, in terms of looking at the individual municipalities, I think Mayor Cousineau has spoken, for example, to the francophone situation. With the age group of our particular population and the growing number of people with dementia and as well the existing facilities that we have, I think one of the areas that's not addressed yet, although Michel spoke to it briefly, has to do with the whole issue of the need for psychiatric intervention. It's one of the major areas that we're facing in terms of this particular region. It's a slightly different issue if we're looking at the Brockville situation, where our psychiatric population moves to.

Again, we have a very cooperative group here looking at that as a specific situation in Ottawa-Carleton in terms of either dealing with that population within our existing facilities, which relates back to a previous issue we discussed, or in fact adding to the existing population.

So I think when we're looking at the type of placement of individuals and the type of accommodation that will be allowed under this funding formula, it makes it very difficult to react to specific community needs that may exist. In the regional homes, for example, we traditionally started with what were euphemistically called special care units and then worked up to developing specific programs for the demented. Now, with the possibility of younger people and particularly with a psychiatric mix and with, as the Perley Hospital has indicated and will address, the change in professionalized staff, we're concerned about our ability to react to specific needs in our community that may not be similar to other areas.

Mr Cousineau: If I may add, our plans were to downsize Island Lodge like I mentioned before, and the plans were to transfer 44 francophone clients over to Centre d'Accueil Champlain. Of course, we didn't have the extra beds at Centre d'Accueil Champlain, and that would also have meant a longer waiting period for people waiting to get into Centre d'Accueil Champlain. So because we cannot answer these needs now, it created a problem, but we still downsized Island Lodge, so that means there are 44 fewer beds there than we had previously.

The Chair: Thank you very much again. I regret that we don't have more time. I know there are other questions, and the Chair always has to be the heavy.

Mr Clark: I can only tell you, Charles, that we have appreciated at least the opportunity to try to raise some

issues. We share with all of you the concern for the cost of the system and the concerns for recognizing the needs of the elderly, especially since the problem is going to get bigger; it's not going away. We hope that your deliberations result in a more sanguine model, if you want, and maybe there'll be some creative new ways to do business. We're not opposed to any of them. Thanks again.

The Chair: Thank you all very much for coming today.

PERLEY HOSPITAL

The Chair: I would now like to call on the representatives from the Perley Hospital if they would be good enough to come forward. Good morning and welcome to the committee. Please make yourselves comfortable. Once you are settled, if you would be good enough to introduce yourselves for the members of the committee and for Hansard and please proceed with your presentation.

Mr David Webber: My name is David Webber. I am the treasurer of the Perley Hospital, a trustee and a member of the board of directors. With me is John Lupton, the executive director of the Perley Hospital and also Mimi Lowi, assistant executive director of the Perley Hospital.

I guess the Perley Hospital represents the next stage in the evolution of long-term care from homes for the aged to chronic care. I know many of you around the table have actually visited the Perley. You're aware of the physical states of a lot of the people who are in the Perley Hospital and realize that, with an average age of about 85, the people in the Perley Hospital are well advanced on the normal process of dying in many cases.

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For those of you who haven't been to the Perley Hospital, the Perley Hospital was founded in 1897 and is a 202-bed chronic care and rehabilitation hospital which has a long history of service in the Ottawa area.

As treasurer and chairman of the finance committee, I can assure you that the Perley Hospital is a frugal and low-cost facility. Around the finance committee, I think we've coined our slogan as "frugal but caring." Our cost per patient day is the lowest of any chronic care hospital in the province of Ontario.

We have received accreditation from the Canadian Council for Health Facilities Accreditation and last year, on October 1, 1992, the hospital also accepted responsibility for running the 150-bed Rideau Veterans Home on Smyth Road and thus the board is now responsible for a total of 352 beds.

As many of you are aware, the Perley and Rideau Veterans' Health Centre is being planned. It's a new 450-bed facility for the Ottawa area which has been approved. It's to replace the 75-year-old Perley building and the Rideau Veterans Home, which like many of the buildings was built as temporary accommodation in 1944 and is still there as temporary accommodation in 1993.

Construction is expected to begin later this year with completion slated for 1995. We aware that it is the Ontario government's wish that the new health care centre be designated as one of the first long-term care centres. This in itself has presented a number of challenges in the planning process and in many ways the new Perley-Rideau veterans

facility will be the leading edge of the new wave of long-term care

We appreciate the opportunity to comment on Bill 101. At the Perley, we support the five objectives set out in the former Minister of Health's statement to your committee. We applaud the government's objective to develop community programs which will enable the elderly and others to stay in their homes. At the same time, I don't think we should forget that there will always be a proportion of Ontario's population who will be too frail or too sick to be cared for in their homes. These citizens make up about 5% of the elderly and we will always need services in facilities such as the Perley Hospital.

It is also important that our senior citizens have the opportunity to choose which option best suits their individual condition and circumstances. We had proposed to comment on four key aspects of Bill 101: governance and accountability to the community, funding, the access and appeals process and standards and quality assurance.

On the first issue, governance and accountability, hospital boards have worked hard to make sure that we represent our local communities, and this is something we always have to work at. It's not something that happens automatically. We go out and search within our communities to ensure that we represent the communities of both our patients and our future patients.

Unlike our colleagues at the hospital boards, conservation authorities, municipalities or government agencies, hospital directors serve without remuneration or reimbursement of any kind. We serve because we are committed to the mission of the facilities which we govern and it is our goal to ensure excellent patient care. We represent local citizens to see that the facility is accountable to them and that the taxpayer is receiving good value for funds spent. An opinion poll shows repeatedly that the public is well pleased with the performance of hospital trustees in Ontario.

Bill 101 makes no reference to governance, and we believe that it's important that the accountability and link to the community be maintained. Many of you are aware of the hearings that went on throughout the province last year—I see Paul Wessenger smiling—on changes to the Public Hospitals Act. I'd like again to reinforce my congratulations to Paul for his patience for the long process of going through changes to the Public Hospitals Act.

Many of the briefs during those hearings focused on this issue of governance. I think there were many good issues brought up. We were made aware of the extreme sensitivity of many communities and many organizations involved in the governance of hospitals to this specific issue of hospital governance and how they relate to their communities. Again, congratulations for your fortitude.

In our opinion, neither the proposed regulations, service agreements nor a government-run system of rigid inspection can really replace the knowledge and experience of community-based trustees. As well, community-based volunteer trustees also serve with distinction on district health councils. We agree with the government that the role and responsibilities of district health councils should be strengthened. We would like to see that happen right away. Local councils are much more attuned to a

community's health care needs than sometimes the public servants based in Toronto, and long-term care offices are, in our opinion, an unnecessary level of bureaucracy which would divert badly needed funds away from care for the elderly. We believe these functions should be transferred to the district health councils.

The Perley believes that the new long-term care facilities should maintain governance structures which compare now with those in place in chronic care hospitals and homes for the aged.

The second issue is funding. We commend the government for establishing a new funding system based on levels of care in nursing homes and homes for the aged. However, there is no mention in Bill 101 about funding for long-term care facilities such as the new Perley and Rideau veterans' home, so we cannot really comment on the funding implications. However, we believe there is a very real danger that standardized levels of reimbursement will lead to standardized levels of care for the elderly.

Certainly, in our dealings with the government regarding plans for the proposed Perley and Rideau Veterans Health Centre, it is clear that your planners are looking for even lower costs than the present frugal levels of expenditure of the Perley. The Perley's operating costs are at the moment approximately \$215 per patient day, and with the new Rideau Perley veterans' centre, I think the Ontario government is looking at approximately \$185 per patient day. Given that the Perley is already at the lower end of the scale, I think that's the direction which we're getting in terms of reducing the costs even further, not even taking into account inflation.

There is no doubt that redirection of long-term care has developed high levels of expectations among Ontario's elderly. We commend the government in calling for the development of a care plan for each patient or resident, but once written, there must be some assurance that the services needed can be provided within the funding available. All of you have probably heard of this figure of between \$85 and \$90 per patient day being mentioned. We question whether in fact facilities will be able to deliver what the care plans call for.

We understand that all long-term residents will be assessed once a year and funding will be tied to the classification of residents, but we know from our experience at the Perley that a resident's condition and care needs change, often seriously, much more frequently. The funding system must be flexible enough to take such changes into account and not just rely on an annual assessment.

The third issue is coordinated access and appeal process. According to Bill 101, individuals will be provided with a local single point of entry to the long-term care system. A mechanism will be created for coordinating and managing access to facilities. Facilities will be required to accept eligible persons whose admission has been authorized by a designated placement coordinator. We find it difficult to comment on the full scope of the placement coordinator until the details of the regulations are issued.

As you heard from the presentation of the region of Ottawa-Carleton, Ottawa-Carleton already has a well-established placement coordination service which since

1976 has successfully promoted collaboration among all health care facilities in the region, including acute care hospitals, nursing homes, homes for the aged, chronic care hospitals and rehabilitation centres, and has ensured effective and efficient placement of individuals requiring care in long-term care facilities. The placement coordination service acts as a gatekeeper and provides for screening of applicants, maintenance of waiting lists, advice to individuals and families on access to health care facilities and assistance to those who require priority access. Thus, Ottawa-Carleton region doesn't really need any new process or individuals to achieve the objectives of the amendments to Bill 101.

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There are two elements of the current system that Bill 101 I think ignores, which we think should be maintained.

First, consumer choice of location and type of placement should remain a key factor in selection of an appropriate placement. Legislation suggests that admission should be based only on the applicant's health care needs with little or no consideration of the social needs, preferences and resources. Preferences of individuals along cultural, religious, ethnic, linguistic and geographic lines, should be preserved.

The second issue is that now facilities have the right to define their own admission criteria. These criteria are not developed in isolation, but through consultation with the community and other health care facilities and through gathering data. The right of determination by facilities should be preserved. Facilities should be able to refuse an application based on the facility's physical and human resources and the ability to meet an applicant's individual care needs.

For example at the Perley, as I said, the majority of patients are very old and frail. I sometimes think it is grossly unfair to suggest moving in some terminally ill younger patients in the 30-year-old age group and putting them in the same ward or the same system as individuals who are in their 90s, making all sorts of noises. It really is not fair on either of the patients, in our opinion.

We also think the legislation fails to address the issue of planning. Local collaborative planning among key players, including community health, social services, home care, acute care, chronic care, rehabilitation and long-term care is vital in determining the scope and type of programs and services offered by each facility. The planning process should lead to the establishment of specific admission criteria for each facility covering the range of needs of the community. This integrated planning approach has been used by the region of Ottawa-Carleton through the regional geriatric program and also the continuing care board of the district health council.

One final point about the placement coordinator is to raise the following questions which should be addressed by Bill 101 or the regulations to the bill. Who accepts liability for placement of an individual? The bill relieves the placement coordinator of this liability. We believe the coordinator should not be exempted. Second, what are the qualifications of the placement coordinator in his ability to assess accurately the individual's care needs? Third, if the

placement coordinator is to be the new gatekeeper, will the placement coordination service be accessible 24 hours a day, seven days a week? It should be.

On the question of appeals process, we support the government's efforts to provide equal access to facility services through the proposed placement coordinator. We do believe that the appeal process is inadequate. It fails to address the rights of the individual to appeal the selection of a particular facility and it also fails to address the right of a facility to appeal the decision of the placement coordinator and question an individual's appropriateness for admission.

We recommend that the appeal board should have at least three members constituting a quorum, should hold hearings locally, should be able to receive an appeal from either an individual or an institution and make a decision within 30 days. We believe this approach would reduce the agony and trauma to an individual and family awaiting placement, reduce the cost of a lengthy hearing process and reduce the potential arbitrariness of decisions by one individual.

On the fourth issue of standards and quality assurance, according to Commissioner Lightman in his report, A Community of Interests: A Report of the Commission of Inquiry into Unregulated Residential Accommodation, he stated a number of compelling arguments against extensive and comprehensive government regulation. These comments are relevant to the government's attempt in Bill 101 to increase the role of inspectors and enforcement:

- Rules and standards determined politically and bureaucratically and enforced by government inspectors leave no opportunity for residents to be involved in decisions about their care.
- The more extensive the inspection, the greater the staffing and administrative costs to the system.
- Standards imposed by government are usually the basis for minimal requirements and there is no incentive to improve the quality of care and services.
- Government sanctions are not imposed, even though standards are not met by facilities because of difficulties in satisfying legal due process requirements and the unwillingness of government to force closure of such desperately needed long-term care facilities.

I'd like to quote Dr Lightman, who said, "We must ask if scarce public funds are best spent in building an endless regulatory system given that every dollar spent on a regulatory system cannot simultaneously be devoted to community-based programs in service delivery and, I would like to add, devoted to services and programs to residents in long-term care facilities."

The Perley would like to provide its strong support of Dr Lightman's concerns about overregulation.

The Auditor General's report of 1990 stated, "Monitoring of quality of care in nursing homes requires significant improvement and violations of many provisions cannot be successfully prosecuted." So rather than expanding the adversarial application of a rigid, bureaucratic system of inspection, we recommend that accreditation, peer review, adherence to existing standards for health professions and continuous quality improvement be used to ensure the

accountability of long-term care facilities to the government and to the public.

We further recommend that the independent Canadian Council on Health Facilities Accreditation process be used as the primary mechanism to measure compliance with nationally established standards for long-term care facilities. The council's process is an extremely positive one, emphasizing education and coaching. The objective of the accreditation process is to have facilities strive to continuously improve and enhance the quality of care and services it delivers to its residents.

We suggest that only when a facility fails the Canadian Council on Health Facilities Accreditation should Ontario require a facility to be inspected by government inspectors. On an ongoing basis, the government should provide assistance to facilities to adhere to standards by providing consultation services by the existing government administration.

We would also raise a number of issues about the proposed inspector and inspection process: For example, what are the qualifications for the inspectors; who will be liable for the results of the inspection; will the inspectors be locally based and familiar with resources available in a particular community?

To conclude, we've only commented on four areas contained in Bill 101.

In governance and accountability to the community, we emphasized the strong need to maintain excellence through the continued use of voluntary trustees drawn from the local community.

In funding, we stressed the importance of providing flexibility in funding to reflect varying levels of care.

In access and appeal process, we spoke about the need to recognize the elderly person's opportunity for choice and preference along cultural, linguistic and religious lines, and we also questioned the appeal process.

Finally, in standards and quality assurance, we opposed vigorously the proposed rigid system of inspection and suggested instead that accreditation by the Canadian Council on Health Facilities Accreditation is a much more acceptable and modern alternative.

On behalf of the Perley, we'd like to thank you for this opportunity to appear before you. For those of you who haven't visited the Perley Hospital recently, we'd be delighted to have you visit at some point in time if you're in the Ottawa area.

The Chair: Thank you very much. As you noted at the beginning, your organization is in the forefront of change. I think I can tell you that it was with some anticipation that committee members were awaiting your presentation today. I know there are a lot of questions and I regret at the outset to have to say to members that we are very tight today on time. I would ask, and I know members are skillful at getting many questions into one—

Mr Jackson: The Chairman is very liberal, there's a difference.

The Chair: A good thing, too. But if we could just be aware of that so that we could maximize our time, and we'll begin with the very skillful Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. I have a number of questions and I'll try to be short. First of all, with respect to your present placement coordination agency, I'd like to assure you that the consumer choice aspect will be continued and in fact that agency will be designated to continue that role. Is it now available 24 hours a day?

Mr Webber: It is not available 24 hours a day at the moment, but that is in fact a shortcoming of the system, in my opinion.

Mr Wessenger: With respect to your concerns with respect to funding, I understand that the funding will continue at the same levels for the three institutions that are going to be continued. I would just like to throw out to you that it seems, with the new facility and the combination, there ought to be funds freed up to enhance services because of the increased efficiencies of a single institution. Is that not fair to say?

Mr Webber: Perhaps I'll refer that to John because there will be a number of new features in the new facility.

Mr John Lupton: I think that's a fair statement. We're certainly playing a new ball game with the ministry's long-term care division. In general, there's been a meeting of the minds. We're going to be expected to run the new facility with a lower per diem cost and we think we can do that.

I don't want to go into the details this morning, but we do have some difficulty over the cost of the new beds. There are going to be some new beds in the facility, more than the present total of the Perley, the Rideau Veterans' Home, the veterans in the military hospital, but that's a different issue. I'm sure we can resolve that.

We're going to see a per diem of about \$185, as our treasurer said. I hope none of you saw me on television last night, but if you did, what I said on television last night was that this called for a new approach, a different mix of staff, probably less professional staff than we've been accustomed to in the past but, by and large, I believe the new centre will provide the same tender loving care kind of approach that we have for nearly 100 years in this city.

Mr Wessenger: Just one last question. There've been a lot of concerns raised with respect to the accreditation process, the fact that it's only three years. The fact is that the experience in nursing homes is there have been several accredited homes that have had many problems and complaints. Would you agree that there should be an inspection process but it should be more complaints based? Would you agree with that aspect?

Mr Webber: There will always be a few facilities that may cause problems. By and large, the vast majority of facilities are operating well and get very good results out of the accreditation process. It would seem to make sense to focus the attention on those ones which require close monitoring, but have a general system of the accreditation process which seems to work well for the vast majority. I think in the province of Ontario, in the system, people have a reasonably good idea of which institutions need more review perhaps.

Mr Wessenger: Is it fair to say the present system, as far as you're concerned, works fairly well?

Mr Webber: In our opinion, it does, yes.

Mrs O'Neill: I'm pleased that you spent as much time as you did on the inspection and your attitude towards the new thrust which we also have a great deal of concern about, and fears. You have explained your affinity for the accreditation and I think that's good.

I have a couple of questions that I'm going to roll into one. The Alberta classification system: I wonder if you've studied that, commented on it and seen it transferred into Bill 101. I'd like you to tell me where you've been with the district health council in Ottawa-Carleton on Bill 101, its role there, and how you see the district health council continuing, because you seem to have a feeling that's going to be a new higher-profile role for the DHC.

Mr Webber: Can I refer that to Mimi Lowi who is very involved on that side?

Mrs O'Neill: Certainly.

Ms Mimi Lowi: First of all, in terms of the Alberta classification system, we were classified as a facility and felt that the classification system did address the personal and nursing care needs but not the other kinds of needs of the patients, of which—one was addressed before, the issue of quality of life—there are other aspects, such as the rehabilitation-restorative care needs. Really, the classification system does not address that specific aspect, so from that point of view, we've got some concerns because of the focus for nursing and personal care. It deals primarily with activities of daily living and doesn't deal with some of the specialized nursing needs and care needs of an individual; so from that point, concern.

The other aspect is the district health council and I think in Ottawa-Carleton we're very proud of the role the DHC plays in coordinated approach to planning of a continuum of care and we've seen it work very well with the establishment of the regional geriatric program and the coordination of services through placement coordination services, as well as overseeing, meeting the needs and the collaboration between different types of facilities. So from at least my point of view—

Mrs O'Neill: Have you begun the work on Bill 101?

Ms Lowi: Yes, we have. We've started to look at a multiservice agency just recently and began to look at reviewing the terms of reference and membership of the continuing care board of the district health council.

Mr Jackson: Am I to understand, Mr Webber, that you haven't consummated your negotiations with the government about your redevelopment plans?

Mr Webber: The Perley-Rideau Veterans project has been in the works for a long time.

Mr Jackson: I'm trying to get a freeze-frame of where we are at this very moment.

Mr Webber: It's hard to know in this whole process at what point in time you say, "Everything is in place." The funding is in place from the province and from the federal government, which is a major contributor to the project.

The pre-construction operating budgets have been approved, and I say more or less, because there is still some negotiating on certain elements of it.

Mr Jackson: I have a sense of that. Can you share with the committee briefly the shape of the new configuration with respect to which numbers of beds have been reclassified?

Mr Webber: All of them, but perhaps I'd like to ask-

Mr Jackson: Absolutely every one of them?

Mr Lupton: Very briefly, this project started off, it was approved—I don't know if one's allowed to say the word in the room—in the Liberal era.

Mrs O'Neill: We are here. We still exist.

Mr Lupton: I think it was when the Honourable Murray Elston was the minister in 1988, something like that.

Mr Jackson: In fairness, in the briefness of time we have, I want to get a snapshot today and not the history of this. I know the facility.

Mr Lupton: Cam, I just want to say it started off as a 450-bed chronic care facility. Today it is a 450-bed long-term care facility. When we were first told to change in 1991, the board chairman said to me: "What is a long-term care centre? What are long-term care beds?" I said to to him: "I haven't the slightest idea. I've never heard those terms used in Ontario before."

Mr Jackson: I recall; we've had this discussion before. But at this point, you must have gotten some indication from the government as to what that means and what that translates into, the level of care and staffing needs of the patients as reconfigured. I don't wish to build on your comment to the media last night, but in the practical world, discussions with the government couldn't have occurred without some clarity as to levels of care required when dealing with a redeveloped, reconstituted facility.

This is our only opportunity since we've been to Windsor and didn't have the same opportunity to talk to a chronic care hospital there, because it's not quite comparable. Unfortunately, we're under time constraints, but I've been waiting for this meeting for some weeks. I want to get from you for the record the nature of those discussions with the government. What clarity, what assurances, what have have you been given? There are a lot of chronic care hospitals in this province that want to know what's happened and want to get a sense of what their new frontier is. Your new frontier is fairly clear. Their new frontier is completely without any real awareness of what's going to happen.

Mr Lupton: Let me say it has been very cloudy in the past. It's very clear the government policy about long-term care centres has been developing, really, as we've tried to develop our plans and as our architect tries to design the building. The long-term care division has been developing policies as we go along and we're still in that state now.

The first question we said to government was: "What do you want us to do in this new building? Who are we going to look after? What's the difference between a long-term care centre and a chronic care hospital?" They said, "You will be looking after exactly the people you do now,"

the people David referred to, average age 86, very old, very frail and very sick. With the last one, the long-term care division sometimes, I think, has some difficulty realizing just how sick. We are not just a home for the aged.

In addition—this is what I think really surprised us and pleased us—we got the government's confidence. We were also told there were six or seven new categories of people we would be expected to look after in a long-term care centre, and these are what Mimi and I and David would call subacute—patients who are in need of dialysis, intravenous therapy, tracheotomy care, irrigations and medical emergencies like pneumonias, heart attacks, urinary tract infections. Some of those we don't look after now.

We are delighted to do it, but we've had some difficulties, and I think these are ongoing: On the one hand to be told we're going to do what we do now, plus all these new categories, which are pretty challenging, some of them—tracheotomy care, for example, dialysis—yet clearly we are going to be expected to do it at quite a substantially lower per diem cost than we're doing it now.

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The way I tried to deal with the question on the media last night was to say that we are going to have a different mix of staff. We are going to have fewer professional staff. All I can say is, if you're at the leading edge of the reform of long-term care, then you have to give it a try. We are prepared, and at the moment our board I think is prepared, to give it a try. We're a bit nervous about it. It seems to us the demands that are going to be made upon us—we have a long tradition to maintain in the Perley—seem to be a bit incompatible with the resources we are going to be given. but the present policy of the board, with the support of the long-term care division, is "Well, we'll give it a try." I don't think we have any other alternative, but perhaps I should defer to a board member. In effect, Mr Chairman, I don't think we have any other alternative, so we're going to give it a go.

Mr Jackson: I appreciate your candour. There is no question that the Perley is between a rock and a hard place. The government's chosen, for whatever reason, to make you its watershed, and in so doing the experiment begins and may end there.

I have very grave concerns about the future role of chronic care hospitals in this province, and for a whole cohort of our seniors who are receiving quality-of-life assurances in that environment which cannot be met in a long-term care facility. I see nothing that will relieve my concerns in this area, but I thank you for your very candid responses. I'm not trying to be testy. I'm very, very concerned about the future of our chronic care hospitals in Ontario.

The Chair: Again, I regret that time constraints won't permit any further questions. We thank you very much for coming. If I could play upon the marital theme of Mr Jackson's comments in terms of consummation, we hope as things go forward, they do work well. We certainly recognize that you're headed down a most interesting road and we wish you all the very best.

COUNCIL OF FAMILY/COMMUNITY ADVISORY BOARDS

The Chair: May I next call upon the representatives from the Council of Family/Community Advisory Boards.

Mr James Lumsden: Thank you for affording us this opportunity to speak with you this morning on long-term care, with particular reference to its delivery in a nursing home/home for the aged setting. Our council represents some 1.400 residents.

The Chair: Could I just ask if you would identify yourself for Hansard.

Mr Lumsden: My name is Jim Lumsden. I'm the chairman of the Council of Family/Community Advisory Boards

The background of our group is set out in the attachment to the written submission you have received. I will try to cover most of the points in there within the general time frame allotted to me, but I will certainly stress what we see to be the most important ones.

In the 20 months we have functioned, we've recognized three significant matters:

First of all, there is a need for some organized effort to interface with the management of the home on issues which relate directly to the operation of that particular home.

Second, we see a requirement to maintain contact with external agencies whose policies and sphere of influence affect the quality of life and the care of the residents in these homes.

Finally, we've concluded there seem to be some deepseated prejudices and differences among the care providers which are in large measure the outgrowth of vastly differing and inequitable funding arrangements. We consider this condition to be detrimental to the most effective operation of the homes from a financial perspective, but more importantly, it is detrimental to the delivery of the best possible care to the residents.

In general, we support the basic thrust of the redirection. The emphasis of increasing the community-based services so that seniors may remain in their communities for longer periods is a laudable objective. It must, however, be properly and equitably managed and funded and it must not be undertaken at the expense of those who, of necessity, require care in an institutional setting.

Our aim is to ensure that all are able to avail themselves of the highest quality of care. Its achievement though we believe to be dependent upon four factors: First of all, a funding formula which is directly related to the required care resource input; second, universally applicable standards, varied only on care requirements as opposed to the present profit/non-profit orientation; third, a single source funding beyond the consumer copayment input, and finally, a set of mechanisms that will assure universal accountability and compliance.

In the introduction of the bill in late November, the then minister set out four goals that she considered necessary to achieve this improvement of quality care for residents. They were: first of all, to establish a fair funding scheme in a not-for-profit delivery system; improved accountability to residents, families, workers and government; a consistent resident payment policy, and provision for coordination of eligibility and admission decisions. I believe if you consider those two positions, there is a general constant in the objective of achieving the best quality of care.

We see this bill as the platform leading to the attainment of that objective and thus we welcome it. There are some differences of course in our approaches, and that's what I hope to talk about or touch upon this morning.

The present myriad of varying funding formulas has produced inequity and serves certainly as a serious impediment to laypersons such as myself to a reasonable understanding of the means whereby we care for our elderly. Fair funding will no doubt require some additional funds. However, we believe the point of departure in accessing this must be an examination of the redistribution of the total existing public funds now supporting such care, regardless of whether they are provincial funds or municipal funds.

We believe the province is doing such a review. Its fairness and equity of course can only be totally judged when the full details are available. However, there are indications of red-circling which are already raising our fears that the desired level of equitable distribution of the available funds will be marred even before this project is launched.

This fear is further strongly reinforced by the December 1992 ministry-commissioned consultants' study by Atkinson, Tremblay and Associates. I will concede at this point that the documentation in there is hypothetical. However, when one considers looking at the detail there, the data in there and the timing of it, one has to conclude that it is as close to reality as we will likely ever get.

A document outlining the conclusions that we've drawn from that report is attached to this written submission. It is an extremely interesting but distressing document. It suggests the province is contemplating an input of \$4 million less this year than last, rather than the much-touted increase of \$56 million.

We talked about redistribution. However, there is no such redistribution under way or even contemplated in relation to the municipal funding. Mr Clark referred to this earlier. In 1991, \$9.8 million—my calculation—was directed to the support of 679 residents in Ottawa-Carleton's municipally operated homes. They house some 22% of the total residents. The remaining 2,300 received not one cent of those municipal funds, while the favoured minority each had their care subsidized by \$14,000 annually.

In addition to this, the 1,643 residents in nursing homes see an average of 5% of their funding contributed to the coffers of the municipality in municipal and business taxes to support this subsidy of the few. This latter levy upon the elderly is certainly inequity at its most iniquitous. Rather than provide for equitable participation in these tax-derived funds, it appears this inequity is going to continue and it seems as if it is going to be encouraged.

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The inequity seems to be rooted in the private not-forprofit debate on the delivery of care. Let's remember that the primary matter for concern is the equal treatment of all who must avail themselves of institutional care. The Ottawa-Carleton example demonstrates that the pursuit of the not-for-profit delivery mode seems to pre-empt the primary concern, as well as staggering the imagination in relation to the wide gap in provided funds. Let me elaborate.

First of all, a nursing home functions on \$77.50 a day per resident, while Ottawa-Carleton's municipally owned homes for the aged require \$146 to deliver the same service. The provincial average, I understand, is somewhere in the range of \$119 a day. This difference is not a function of serving vastly different clienteles. The similarity of the client base was answered in the pilot study on the funding-to-care project and is accepted in the December 1992 study referred to earlier wherein the modelling assumption is that the case mix index is highest in nursing homes. This 90% difference justifies a presumption that both ends of the scale represent some form of injustice.

Why does such an inequity exist? Why would its continuation be encouraged and what remedial measures are needed? As I say, it taxes the imagination.

The goal of fairness cannot be met so long as that inequity is allowed to continue. It can only be achieved by having a single funding source beyond the resident copayment issue. When the issue of municipal funding is raised, I am told it's not a matter for provincial authorities. It may not be at this time, however, it is our belief that innovative, objective, courageous thinking and leadership on the part of you as our legislators can bring that change about. I would suggest to you some radical brainstorming on this issue. You would not be out of order.

There are no doubt some legislative barriers to such redistribution. Whatever barriers exist now must be examined and removed to facilitate more equal and fair treatment. It won't be easy to achieve, but if anyone had told me two years ago that the province and its municipalities would cut a deal on how they were going to fund welfare, I would have scoffed, and I am sure there will be people who will scoff at this particular idea as well.

The bill is the vehicle towards a fairer funding formula. It will require single-source funding to achieve that desired degree of funding. You, as the committee on social development, must be the engine of that change and demonstrate the political will to insist that it include provisions for single-source funding. It's goal is fairness. Amend it to facilitate achievement of that goal. You will contribute in large measure to ensuring that the present disparities in funding in the different areas of this province are overcome.

We, therefore, recommend that all public funding for long-term care facilities be derived from a single source, that source to be the Ministry of Health. To give effect to this, all funding now provided by the province, any of its institutions and any municipal or regional government established by or under the Legislative Assembly, would be placed under the control of the Minister of Health for distribution, in combination with the funding now provided by the province, solely on the basis determined by the funding-to-level-of-care process recently adopted by the province.

Second, we would recommend this committee initiate a review to determine the effect on care delivery caused by the inequity in funding between nursing homes and municipally operated homes for the aged. The disparity in Ottawa-Carleton could serve as a fine focus for such a review.

No matter what though, we will always arrive at the matter of dollars generally and the increase in the residents' copayment in particular. The reports of this proposed increase range from \$10 a day in October, 1991, to \$11.95 in January, 1993. This is a percentage increase ranging from 38% to 45%.

We are not insensitive to the fact that there is a fiscal crisis. We would certainly love to not go to the lowest common denominator, as Mr Clark suggested, but to bring the others up. I wonder if that's reality. We have accepted that there is a fiscal crisis, that costs are rising and that residents and the residents' families are going to have to shoulder a portion of that increase.

Remember, though, that the copayment increases quarterly by an amount equal to the increase in the old age security guaranteed income supplement payments from the federal government. That process has seen the copayment rise by 149%, from \$10.52 in 1980 to its present level of \$26.31. Presumably, this has been insufficient, and a decision has been made to impose an unconscionable single-step increase. Where is the justification for an increase of such a magnitude? We've sought it during the long consultation process that preceded this; we sought it through correspondence with the provincial bureaucracy; we sought it in meetings with provincial officials and finally through the access to information and privacy act process.

To date, no such justification has been forthcoming other than generalities and platitudes, never ever mention of a zero-based review that would give us, the families representing the residents, some idea of what generates a need for such a raise. We believe that such evasion is unsatisfactory. Such a cavalier disregard for the rights of the individuals, those individuals being the residents, to receive this information certainly repudiates the current fashion in bureaucratic euphemisms when we talk about empowering, individual rights, living at risk and the right to be wrong. These are the terms that are in vogue in dialogue and prose. If they are in fact going to be empowered, if they are going to be able to live at risk, then they have to have some information upon which to base the decisions that they are going to take some risks upon; that is not available to us.

However, despite this dearth of information, we've taken a positive position in the belief that responsible persons—and we believe that provincial officials are responsible persons—would not undertake such a radical step unless the justification was available. Accepting that premise, we propose that the increase be implemented over a period of some five years, the same time in which the government proposes to inject its total increase of \$647 million.

We provided tables suggesting the means of implementing that. This has been dismissed on the basis that the government needed the money now and a phase-in was not acceptable. One would think that such a refusal would generate some financial data to support this crushing one-year increase. We have not received it yet.

In any case, a senior member of the government has indicated to me that the actual copayment dollar requirement was not the significant issue. The prime motive, rather, was to create an incentive for persons to opt to remain in the community. The increased cost would hopefully persuade them to seek community support facilities rather than institutionalization.

The thrust is thus to promote the community-based aspect of the program, and the interests of the present residents seem to be secondary. We support the matter of the incentive to community living, but it must not be done at the expense of existing residents of long-term care facilities who cannot avail themselves of the incentive yet will pay the penalty in additional costs that it will impose. If this is the plot that's wanted, then grandfather in the existing residents at their present copayment and increase the rate for those who are admitted after the date of the proclamation of the act.

The ministry's goal is a fair funding scheme. Fair to whom? The government? The taxpayer? The service provider? The resident? All have a stake in fairness, and fairness must be relative and consistent with other similar undertakings. We see rent control as being a similar and relevant undertaking.

You have the opportunity and the obligation to examine what fairness means in this case. We recommend to you that the bill be amended to deal with some limitation on how the copayment aspect of fair funding is to be achieved. We suggest that it continue to permit the cost price index quarterly increases and that this amount be supplemented by an annual amount no greater than the increase authorized under rent control legislation in that particular year. A table showing the results of such a proposal is attached to our written submission.

In her first goal, the minister also referred to the guarantee of non-profit delivery of nursing care and program components of the care. As a council, we fully support this. We do, however, if the current proposal of the three envelope system remains, interpret this as recognition that the private sector is a full and equal partner in the provision of long-term care accommodation. That premise must now be given some meaning.

The private sector operates facilities valued in excess of \$1.1 billion. These were built with privately funded capital. The municipal homes were funded entirely with public funds on a provincial-municipal cost-sharing basis. Charitable homes receive up to 50% of their capital funding from the province.

1110

In Ottawa-Carleton, 69% of the extended-care beds were funded by the private sector at no cost to the tax-payer. This begs the question: Would the province and/or the municipality have filled this void if the private sector had chosen not to do so? We'll never know the definitive answer to that.

The reality of the situation suggests an allowance for private capital investment to provide facilities is clearly justified. What reality also dictates is that the matter of the private sector versus the not-for-profit operation must become a secondary issue, at least for existing facilities. Our primary concern is the equal treatment of persons who must avail themselves of the services of a long-term care

facility. Let us never ever lose sight of that particular objective.

It is immaterial to us whether the delivery system is 100% not-for-profit, vice versa or some combination between those extremes as long as it totally respects the primary concern of quality care delivered in an equitable manner throughout the province. Neither you nor I have the right to allow our personal philosophies to detract from the attainment of that primary goal and our responsibility to the elderly who require care in these types of facilities.

We recommend to you that the bill be amended to provide that all regulations and standards arising from it or pertaining to the delivery of long-term care must be universally applicable. They must be designed with equal and quality care for the residents as their primary aim, and if variation is deemed essential, that variation must be based on the assessed levels of care identified in the classification process as opposed to the present non-profit orientation.

Accountability: The minister's second goal refers to accountability. There have been some excellent measures proposed. A consistent inspection process which has been discussed at length here this morning is envisaged. This is a process now in being in nursing homes. Its broader implementation is welcomed. The total effectiveness, however, will depend upon the philosophy of inspection with which the inspectors are imbued. In must be one which provides for privileged communications between the inspectors and the staff members. It must not be an adversarial choice for inspectors but rather one which sees inspection as an operational assistance program. There would be objective reviews and an opportunity to share the best management practices that inspectors encounter throughout their tours of the varying facilities that they deal with. We recommend to you that the regulations be developed to support an inspection process that reflects a positive, constructive, self-initiated and compliance-oriented philosophy of inspection.

There's a requirement for quality assurance plans as part of the accountability. These should be designed on a continuous improvement philosophy as opposed to a tendency to assess blame. It's a process that requires everyone, including the administrators, the directors of care and the supervisors, to be accountable and to accept responsibility. It's not a process for blaming just those people who are down at the coal face.

The plan must be seen as a portion of the service providers' responsibility to the residents. The sections providing for quality assurance should be expanded to reflect that accountability, and they should be part of the notice to residents that reflects this requirement and not left to the regulations.

There's also a requirement for notice to residents. In homes for the aged, the requirement is simply to provide this information to the resident. In the case of nursing homes, the notice must be provided to the resident and to the residents' council. We are not able to understand the rationale for this difference. We can only conclude that boards of managements and boards of directors are seen as providing a means of advocacy for residents in homes for

the aged, and the closest match to this in nursing homes is the residents' council.

Regardless of this rationale, one must really consider the situation with regard to residents' councils in many nursing homes. They make a significant contribution on a day-to-day basis to the internal operations of the home. However, their ability to advocate on behalf of residents is minimal. Nursing home residents thus lack the representation that should be offered by boards of directors and boards of management in homes for the aged. After all, these residents are the primary group to be affected by the proposed changes to this environment which is their world. It is imperative that the means for such advocacy be established immediately.

We see the family-community advisory board as providing such a means. They represent the interests, concerns and rights of the residents and their families to bodies involved in the implementation and governance of long-term care, to governments at all levels and to the public in general.

Our intention here is not in any way to ascribe the advocacy function that is foreseen in the recently passed advocacy legislation to the boards. Rather, it would see problems solved in a milieu of sensitivity between families and residents and with facility management through rational discussion and problem understanding without the intervention of an advocate. This minimizes the need to seek the more formal form of individual case advocacy without denigrating the value of the formal process when it is truly merited. It would also minimize the possibility of antagonism which might arise when the formal process is misused.

This role must be recognized in legislation now so that those who are greatly affected by the contemplated policy redirection will have an officially recognized voice in its formulation. We therefore recommend that the bill be amended to include provision for mandatory establishment of family-community advisory boards in all long-term care facilities.

The matter of accountability also presumes that the person to whom accountability is owed must have a clear understanding of his rights and expectations. The Nursing Homes Act declares in very clear terms that the home is primarily the home of its residents, and it enunciates the need to fulfil the physical, psychological, social, cultural and spiritual needs of the residents. It does this in the "Residents' bill of rights." Such a clear and unambiguous statement is not present in the other primary acts. The minister's goal of accountability would be greatly facilitated if that statement of rights was universal in all three primary acts.

The third goal foresees the establishment of a consistent resident payment policy. We've addressed the issue of how the resident input into that consistent policy should be established under the goal of fairer funding. However, these goals are not mutually exclusive. When one seeks a consistent policy and a fairer scheme for funding, we presume that this is on the basis that service delivery is so similar as to justify the consistent and fair funding arrangement. The regulations under the various acts have variations which make one wonder at this time if they really

have a relevance to the same aim. These regulations must be consistent and have equal application.

Standard care delivery must commence on the same day that standard charges are imposed. The present regulations under the Nursing Homes Act provide the greatest level of clarity, and they are an appropriate point of departure to facilitate this standardization. Regardless of what you follow, the principle must be consistent, and fair funding must be accompanied by consistent and fair delivery of service.

Failure to balance this common copayment level with common delivery standards will convince many of the sceptics that the fairer funding concept is merely a funding grab at the expense of the elderly. This belief has ever-increasing currency as the increase in copayment increase rises to meet the funds available.

There's also a need for common interpretation. Let me give you just one small example. The term "extraordinary event" is referred to in all of the three acts that are going to be amended. What we would see here is that the same set of circumstances would be regarded as an extraordinary event under all of the acts. For example, if an overexpenditure of a budget at the end of a fiscal year in a charitable home for the aged is seen as a circumstance which would merit special allocation of funds, then a similar event in a nursing home would elicit a similar response.

We see placement coordination provisions as a progressive move. It must, however, exercise some degree of choice by informed prospective residents. It must also respect to the greatest degree possible and desirable ethnic or religious affiliations or expectations in a particular facility. We also note the appeal process has been strengthened to the point of going to the Divisional Court. Our only concern there is that in some way it must not be allowed to become a litigation nightmare. The elderly do not have the time to wait for those sorts of decisions.

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If the present plans for implementation are put into being as they are conceived, it will represent a downloading in a single year of 75% of the total funding increase to residential care, and 23% of the total proposed increase to the overall program, on to the shoulders of the residents of long-term care facilities. This is unconscionable. It is even more so when you consider that they will be the only persons in the long-term care continuum to have a user fee or copayment imposed. Residents are prepared, where possible, to shoulder fair cost increases which have been justified and that are implemented in a fair and phased manner.

In conclusion, I would ask you to try to envisage that you lived through the Great Depression of the 1930s, as most of our residents have, and all the hardships that it imposed upon those people. Envisage the values that those who lived through this depression and period of material deprivation came away with. Now envisage that someone has suddenly told you that your costs are going to be increased by \$333 a month, or almost every spare dollar that you receive. You'd have to forgive the elderly if they thought the Great Depression had returned and they were no longer living in the age of social enlightenment.

The elderly of this province are looking to you to help to ensure that funding of care in long-term care is placed on an equitable basis. Their goals and the goals of this bill, which I initially set out, are quite clearly in consonance. It is the process leading to their attainment where there are some differences. The suggested adjustments to Bill 101 will provide the basis for reconciliation of those differences. I believe that open and good faith dialogue between the government and the most important player—that is, the consumer or resident—can function to their mutual advantage.

Ladies and gentlemen, on behalf of my colleagues and the residents whom we represent, I'd like to thank you for granting me the privilege of speaking with you this morning.

The Chair: Mr Lumsden, I want to thank you for a very full presentation as well as for the document and some other material that you've attached. You have dealt very clearly with a number of issues, and I just regret very much that our time is up and we're not going to be able to get into questions. But I think the nature of your brief, the specifics of your recommendations, have been very clear for the committee, and I want to thank you for coming.

Mr Lumsden: Fine. Thank you very much, Mr Chairman.

The Chair: If I could then invite the representatives from Para-Med Health Services to come forward. And I'd just say to the representatives of the VON, please do not despair; we will be with you shortly.

VICTORIAN ORDER OF NURSES, PEMBROKE AND SOUTH RENFREW BRANCHES

The Chair: Are there representatives from Para-Med here? If not, I would ask the representatives from the Victorian Order of Nurses, South Renfrew and Pembroke—if you're ready, it seems our previous presenter is not here—to come forward, we would be delighted to have you. As I understand it, this is a joint presentation by South Renfrew and Pembroke. We welcome you to the committee. If one of you would be good enough to introduce the others for the committee members and for Hansard, and then have some good Ottawa water, and please proceed. We have a copy of your submission.

Mrs Joan Booth: Mr Chairman, members of the standing committee, thank you for the opportunity to address this committee today. We are presenting in support of the VON Ontario briefing paper regarding Bill 101. We represent the two branches of the Victorian Order of Nurses in Renfrew county. May I introduce Elsa Dann, board member of the Pembroke branch, and Mary McBride, the executive director of the Pembroke branch; Joan Lemay, executive director of the South Renfrew branch, of which I, Joan Booth, serve as president.

The Victorian Order of Nurses is a national, not-forprofit health care organization dedicated to providing health and related services to communities. As a major provider of nursing and other services in the home and community, VON believes that:

Individuals have primary responsibility for their own health. The maintenance of health directly and positively affects the quality of their lives.

The value and dignity of human life is respected. Individuals have the right to accept or refuse health care, to obtain information about their health and health care, to participate with health care workers in making decisions to plan for the provision of their care. Individuals and families are supported so as to enable them to live and to meet death in comfort and with dignity.

Access to comprehensive, compassionate, family and community-centred health and support services is the right of all individuals. Health care providers and consumers collaborate to develop, implement and evaluate services which respond to the expressed needs of individuals, families and communities in keeping with the principles of primary health care.

Volunteers make a valuable contribution by extending and complementing the services provided by health professionals and home support workers. At the local, provincial and national levels, volunteers help to identify needs, formulate policy, plan, promote, support and provide community health services.

Community health services of assured quality are essential. VON has a responsibility to expand knowledge through ongoing research, program evaluation and education.

The VON has been providing services in Renfrew county for the past 80 years. Today we provide about 80% of visiting nursing in the county. The volunteer boards of directors of VON in Renfrew county represent the geographic areas and provide a variety of skills, expertise and community focus in the governing of the branches.

Insert B, which was handed out to everyone I believe, outlines the demographics of Renfrew county as 100% rural; that is, all settlements are under 20,000 population, as defined by government for funding review. Renfrew county is inhabited by a high percentage of elderly persons. Younger people have moved away for higher education and employment. Older adults are also moving into the area for retirement. All projections indicate that a larger percentage of the population will be older adults and that a smaller percentage of family members will live in the area to fulfil the role of care giver.

Our comments regarding Bill 101 are also based on input from Renfrew county participants in the consultation on the Redirection of Long-Term Care and Support Services in Ontario carried out by the government from November 1991 through March 1992. The issues we will address are vision of Bill 101, planning, allocation of resources, quality of care, placement coordination.

Vision of Bill 101: Bill 101 is an incremental improvement in empowering the consumer in that Bill 101 allows for direct-funding grants to the physically challenged; starts to standardize legislation for long-term care facilities but does not replace separate legislation and does not address chronic care beds; ensures consumer access to key information regarding facility services, care, accommodation and consumer knowledge of care plan; allows for appeal process regarding eligibility for service.

VON in Renfrew county supports these incremental improvements and recommends that these changes be expanded to include similar requirements for chronic care

beds and facilities, and requirements for a residents' council in all long-term care facilities.

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Recommendations: VON recommends that consumers have a choice of whether to receive needed services in a facility or community setting within an envelope of available resources. In short, the consumer has the choice of service location within a dollar capitation.

VON recommends that if the consumer requires and they or their surrogate decision-maker chooses facility care, they have the choice of what facility to enter, rather than this being the decision solely of the placement coordinator.

While supporting the incremental changes proposed to protect and increase the involvement of the consumer in their care, VON believes that the tone of the amendments are incremental and not comprehensive and could be interpreted as paternalistic rather than empowering. It would be most unfortunate if this happened. Therefore, VON recommends that the Bill 101 amendments be delayed until the publication and public debate on the government's long-term care redirection policy framework.

Planning: The VON branches in Renfrew county recognize the government's plans to reform long-term care legislation and commends the government for its efforts. We expect that Bill 101 is the first piece of legislation in the provincial strategic plan for long-term care. However, this legislation stands alone and does not envision a fully integrated system of reform. Rather, it fragments the long-term care system into sectors dealing with nursing homes and homes for the aged while completely ignoring other institutions, for example, hospitals with chronic care and community agencies.

By moving ahead with facility legislation outside of the long-term care policy framework, and prior to local district health council planning, the government is not supporting its own direction for a strategic, policy-based approach to the health care system based on consultation.

The legislation allows for the government to designate the number of beds, to require certain types and capacity of beds for certain levels of care, service, programs etc, but does not reference these requirements in terms of any planning process provincially, regionally or locally.

Recommendations: VON recommends that the legislation be deferred until the policy framework is released and debated and the district health councils' planning for long-term care be referenced in the legislation in terms of the designation of numbers and types of facility beds; and, the newly formed district health council in Renfrew county be given time to develop its strategic plans to address the fragmented services in Renfrew county.

Allocation of resources: The people of Renfrew county are concerned about the availability of facility services in rural areas where it is difficult to provide the same level of community services as in urban areas. Renfrew county has a population of 87,000 spread over 763,870 hectares compared with Metro Toronto which has a two million population over 630,831 hectares. The placement criteria for admission to a long-term care facility should consider not only the care needs of the client but the social needs.

There was also support for the relocation of beds for long-term care to local communities to enable the client to stay in contact with family and friends. Bill 101 appears to ensure continuation of centralized funding and the status quo of current facilities. For residents of Renfrew county this means leaving your small community and moving 50 to 100 kilometres to Arnprior, Renfrew, Pembroke or Barry's Bay when this level of care is required.

The people of Renfrew county support plans to include all long-term care facilities under a common funding system and common legislation. Such legislation was seen to allow, indeed require, a facility to provide multilevel care for an individual as needs change and would eliminate the need for the individual to move to another facility when level of care changes. We are somewhat disappointed that this was not addressed in Bill 101, and it would appear that the individual may be required to change facilities to obtain appropriate level of care.

We understand that the government may consider level of payment directly related to acuity of care of the individual within the level of care defined for the agency service agreement. If this funding concept is instituted, we may be encouraging the continuation of the illness and the medical model, resulting in higher costs. VON supports a mechanism to provide for consumer needs and care which go beyond the illness needs, to include rehabilitation, discharge and support to maintaining wellness.

Recommendations: The government should consider a funding system responsive to the resources required to rehabilitate, maintain or improve the level of wellness of individuals or provide care during illness.

Quality of care: The continuation and expansion of the inspection process of homes for the aged ensures compliance with the regulations but does not ensure continuous quality management or customer satisfaction. Bill 101 provides for access by the consumer to key information regarding facilities' services, care, accommodation, consumer knowledge and explanation of care plan and an appeal procedure in the eligibility for service process. There appears to be no provision for an individual's involvement in choosing whether or not to receive a service or in determining the goals and use of resources to achieve these goals, nor an appeal process if the consumer is not satisfied with the care plan or service.

Recommendation: Consider expanding the content of the quality assurance plan to include total quality management which provides the opportunity for a consumer or surrogate decision-maker to have significant input and influence as to care received and an appeal process for consumers who are not in agreement or satisfied with the individual care or services.

Placement coordination: This is the area of greatest concern because Bill 101 speaks only of placement coordinators in relation to nursing homes, charitable institutions, homes for the aged and rest homes.

Recommendations: The relationship between the district health councils, home care, placement coordination services, service providers and their roles in the continuum of care and spectrum of needs should be studied in a more comprehensive manner, as proposed in the redirection of long-term care consultations.

In summary, on December 2, 1992, the Honourable Frances Lankin stated, "The framework for this restructuring is a product of one of the most comprehensive and democratic consultation processes ever undertaken by government...the consultation told us that our long-term care redirection was too narrowly focused...."

Rather than rush piecemeal amendments through legislation, please keep sight of the more comprehensive picture which emerged during 1991 and 1992. Provide the promised report of policy decisions on the redirection of long-term care. Provide the promised implementation framework in the spring. Provide for more discussion and input at the proposed March conference if that is what is needed to built the system the honourable member and her colleagues envisaged.

If the concern is about caring for persons, there will be differences, alternatives and choices within that system. If the concern is about limiting the caring to caring for people, the management has already been replaced by control.

Again, to quote the honourable minister on December 2, 1992, "The government, together with its partners in this endeavour, will be laying the foundation of a system that will serve us for decades to come." Strive for those foundations. Strive for total quality management by funders, service providers and consumers with special needs. Striving for those ideas while adapting to ever-changing social order, while addressing the fluctuating health and wellness needs of individual citizens is something the VON has been learning, practising and perfecting for 97 years in this province.

We need the courage to be caring for persons in a system where there will be local-regional differences, community-institutional alternatives and personal involvement and responsibility in choices; a two-way street in which there will be respect, participation and management as opposed to the cul-de-sac in which people are cared for by placement and control. Thank you for receiving us today. We would be pleased to invite your questions.

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The Chair: Thank you very much for your presentation. As you're perhaps aware, as we've wandered about the province we've met a number of representatives from the VON, and I know I express the view of the committee in saying that each and every presentation, including your own, has not only given us a much better sense of what the VON does in our communities, if we didn't know it already, but has also shown that it's particularly important in addressing a number of regional issues, concerns that would not necessarily exist in perhaps a large, builtup urban area—you come from Renfrew, for example—and that's extremely valuable to the committee. I just wanted to put that on the record before we begin with questions and Ms Fawcett.

Mrs Booth: Thank you.

Mrs Joan M. Fawcett (Northumberland): Thank you for coming. I certainly agree that rural and urban delivery of services are indeed different and that the difference is

important. I think we know that the VON invented home care and certainly continues to provide such a good service; also included in that are the numerous volunteers who are encouraged

Your brief, with the recommendations, is excellent. There was a disturbing report on W5 on Sunday night, and I just wanted to ask you about that. Apparently, Saskatchewan has moved to government-run home nursing care. In particular, they highlighted the Regina health board association, which has taken it over; the VON will no longer do it. I believe that the nurses hope they will be employed by the government now, but most of the volunteers have said they will not work for the government.

I wonder about that whole scene because apparently the government in Saskatchewan has said that it will deliver the services better and cheaper, and I personally cannot see that at all. I don't think that will happen. I just have to think now, with the socialist government here in Ontario, are my fears justified? Do you fear anything like this happening here in Ontario, and if so, do you really think that the services will be delivered better and cheaper? I'd really appreciate your thoughts on that. What do you feel would happen to your volunteers?

Mrs Booth: If I may begin, I don't know whether it's cheaper or not, but cheaper isn't always necessarily better.

Mrs Fawcett: I agree wholeheartedly.

Mrs Booth: I'll pass to my nursing professionals.

Ms Joan Lemay: There is a concern, when you see it happening in other provinces, that the same trend will happen in Ontario. We have a large number of volunteers. Each VON branch is made up differently, but the volunteers start with the governing body of the branch and then some of the branches have programs that are run entirely by volunteers. It is a concern that this aspect would be lost if it was taken over by another organization or by the government.

Mrs Fawcett: I suppose volunteers are very important wherever, but I would think that in rural Ontario this is also a deep concern if you lose volunteers. The providing of services in rural Ontario sometimes can be very difficult because of the distances you have to travel.

Mrs Booth: And that's only as a volunteer? Please, I hope we are valuable.

Mrs Fawcett: Oh, definitely.

Mrs Booth: I believe we are.

Mrs Fawcett: In so many areas, we couldn't exist without you. There's just absolutely no question.

Mrs Booth: Particularly in a rural area, because one of our concerns, which has not been addressed fully, is transportation. You take away your volunteers and you take away the volunteers' cars. I think you may be solving one problem, but you may be creating a monster.

Mrs Fawcett: I couldn't agree with you more. Thank you very much.

Ms Jenny Carter (Peterborough): Thank you, and I'd like to reiterate what people have been saying about your organization. I think it's an extremely valuable organization, and I don't know what we'd do without you. I

think we're going to be asking more and more of you in the future.

You're suggesting that this legislation be delayed, yet we've had people presenting to us, representing facilities, saying that their funding is in total disarray until this legislation goes through. I just wondered if you could comment on that. It seems that this is urgent from some points of view at least.

Mrs Booth: I think we are asking you to delay until what was promised has been provided so that we can see this small part as a section of a much bigger, a much more complete and much wider picture, which was what we had all hoped for. Hope and adrenaline, believe me, were running very high at the end of last year.

Ms Carter: Of course, that is what it is, part of a much wider picture. We're assured that there will be more legislation to come, and I guess we're expecting a policy framework document. Certainly, what we've been understanding from these presentations is that there are gaps in Bill 101 in the sense of what it doesn't say. I think what we can do at this point is assure you that a lot of your concerns are certainly the same as the concerns of the government, and I hope that this will come out more clearly in some of the subsequent documents and legislation.

For example, consumer choice is very high on the list. Expanding community care is very high on the list. Obviously, that doesn't appear in Bill 101 because that is not what it's dealing with. Also, of course, you raised the question of the difference between urban and rural communities as far as delivery of health care goes, and I know from what I have heard in discussions and so on that this again

is one of the issues we are aware of and that we're looking at and that part of the intention of the legislation is to spread available resources more fairly.

Some areas are very well looked after at present, but we're hoping to make sure that those areas, maybe such as your own, which have not done so well are going to be more fairly treated in the future. Hopefully, that should come through as time goes on.

Mrs Mary McBride: One of our concerns is that the term "hopefully" is used, and that's sort of why we're here today. We do understand, at least we believe, that this is part of a bigger picture. These are some of the things that we feel maybe will come in legislation, but we would like to draw your attention to those particular things. Certainly, based on the concerns expressed by the Renfrew county residents in the consultation process, if that is lost, then I think we have lost a great deal in health care.

The Chair: Thank you very much for coming before the committee and also for both presentations. We now have copies of both. We wish you all the best as you go forward in Renfrew in putting together this—I don't know whether to call it this beast of long-term care or this structure. We know that however it evolves, the VON is undoubtedly going to be at the centre of everything. Thank you again.

I'll just say to committee members before breaking that we will reconvene here at 1:15 sharp. I have indicated to the 1 o'clock presenters that we would start at 1:15. We have a very full afternoon, and we have a full evening. If members could organize their time accordingly, thank you. We now stand adjourned.

The committee recessed at 1150.

AFTERNOON SITTING

The committee resumed at 1317.

The Chair: Good afternoon, ladies and gentlemen, and welcome to our third session here in Ottawa, the third session of the standing committee on social development. We're here to discuss Bill 101, the government bill dealing with long-term care.

ONTARIO HOSPITAL ASSOCIATION COUNCIL OF CHRONIC HOSPITALS OF ONTARIO

The Chair: Our first presenters this afternoon are the representatives of the Ontario Hospital Association. I welcome them to the committee and would ask them to come forward. I note that this is a joint submission of both the OHA and the Council of Chronic Hospitals of Ontario. Is that correct?

Dr Wilma Dare: That's correct, Mr Chairman.

The Chair: Fine. It's a pleasure to welcome the past chair of the Ontario Hospital Association. Perhaps, Ms Dare, you would be good enough to introduce your colleagues, and then please proceed.

Dr Dare: It's my pleasure, Mr Chairman. First, I would like to tell you how much we appreciate the opportunity to make this joint presentation to your committee. As you mentioned, I am the immediate past chair of the board of the Ontario Hospital Association. As co-presenter, I have with me today Michel Bilodeau. You heard from him this morning in another capacity. He is the vice-chairman of the Council of Chronic Hospitals of Ontario. Also with me is Mr Stephen Skorcz, the Ontario Hospital Association vice-president for chronic care and mental health. I'm looking forward to their assistance, particularly during the question period.

The Ontario Hospital Association and the Council of Chronic Hospitals of Ontario represent facilities providing chronic care to 12,000 individuals and their families. Chronic care is provided in a wide range of hospital settings across Ontario, including 18 freestanding facilities and units of chronic care in 70%—that's 133—of the province's 190 acute care hospitals. However, all public hospitals in Ontario have an interest in long-term care developments such as Bill 101 because they must be able to shift patients to appropriate levels of care as their needs require, and I emphasize the term "needs."

OHA and CCHO fully support the government's resolve to reform the long-term care system in Ontario. This was stated in our position papers prepared in response to the government's consultation paper Redirection of Long-Term Care and Support Services in Ontario one year ago. Redirection is based on the concept of a continuum of care where patients and families can find the most appropriate services to support their needs over time. Sometimes I feel that we've used the term "continuum" for so long that maybe we have lost the essential meaning. The continuum that we wish to provide, all of us, really must respond to what is a progression of needs, and I think I would like to insert that terminology into our consideration.

During the course of these hearings, you've heard from a number of our members about their individual concerns. You heard from the SCO services integrating from the Perley Hospital. I know that you've heard in your other committee hearings from hospitals of different sorts. We believe the best contribution we can make to your proceedings is to provide a focus on the overall strategic approach that we see being optimal for long-term care redirection. To make redirection work, there must be active collaboration with providers. Consultation by itself is not enough.

1320

The OHA and CCHO strongly believe in the need for a coordinated continuum of care in Ontario, because at present it is so fragmented and uncoordinated. That's the principle we've all been working on since the concept and need for reform was first introduced. The key result of long-term care redirection should be to improve care for the people of Ontario. The redirection should therefore provide for closer relationships among care providers, the creation of clear admission criteria for each category of facility to help determine each facility's role in the provision of care, similar approaches to governance and accountability, and similar approaches to ensuring that certain standards of care are met province-wide in both community-based and facility-based care.

The former Minister of Health, the Honourable Frances Lankin, stated in her comments to your committee on February 1: "What we are attempting to do is understand that there really is a continuum of care that is required, and while we have pieces of it in Ontario now, we don't have good linkages and we don't have the sense of the continuum, that people can enter and exit various points of the system at appropriate times to get the care that they require at that point in time."

We are very concerned with the approach that the government has adopted to achieve these objectives.

In OHA's response to the Redirection paper, we outlined principles to be embodied in the redirection, and this included 10 steps for "doing it right." We have provided you, in an appendix to our brief, a repeat copy of that document. I will refer to each of these 10 steps with a short extract to focus our attention on what we meant by "doing it right." We thought we were most relevant a year ago. We still think that these are very relevant, particularly when we see Bill 101 and fear that it is the beginning of a fragmented approach to implementation of long-term care reform.

Step 1: We should not proceed without adequate information. "The heart of our concern with the proposed reforms is that the government does not know exactly what it is reforming or precisely what resources are, or will be, needed to implement such reforms."

Step 2: We feel that it is vital to work from a blueprint. "Central to any such planning is detailed and accurate information. To date, there is no indication that even a fraction of the information needed in order to draw up a valid blueprint for the new system has been collected."

Step 3: This was mentioned this morning. Build on what already works. "Is there a rationale to change any hospital-based program that works," especially if the government doesn't know if the alternative is going to work as well or be more cost-efficient?

Step 4: We need to build a genuine spectrum of care. "If any part of the system is inadequate, it will increase the pressure on the other elements, thus endangering the entire system."

Step 5: Quite naturally, "Our primary concern is that these [long-term care facilities]"—or I heard the terminology this morning of long-term care centres, such as the Perley—"are meant to replace chronic care hospitals solely as a cost-saving measure, based on inadequate knowledge of the essential care that these facilities provide." It would seem to us that borders on a recipe for disaster.

Step 6: We should acknowledge the importance of health professionals. "Not only will physicians be needed to treat seriously ill people, they will also be needed to care for recovering patients."

That's something we at times lose sight of. We think all of the older people requiring care in an institution are going in, are going to stay there, and there's no recourse for them to exit the system. When we speak of the community level, too many of us forget that older people get sick. Sure, they may require longer periods of treatment, but they also get well. We want to provide the environment, the services, to at the very least maintain their state of health, but also to capitalize on their potential for recovery. This cannot be done without the professional care that is required.

Step 7: Strive for a balanced system. "If it is to function well, each part of the spectrum of care will need the other parts to be working well, too."

Step 8: "We further believe that it would be reckless to implement any new system without first introducing pilot systems in a variety of community settings."

I know that Ottawa-Carleton, as we are very proud of the system we have in place now, would be only be too willing to be one of those pilot settings.

Step 9: We proceed to another rather obvious principle—don't shut down the old system until the new one is in place. We all have the rather startling memory of what happened in the field of psychiatry when countless patients were discharged without appropriate services in the community, and I think this is the danger that applies to the care of our elderly and to disabled young adults.

Step 10: We should ensure that long-term care is part of the overall health care system. This is very vital. When we think of the very major restructuring that is going on in the hospital-based part of the system and in the health care system generally, long-term care reform must be considered not in isolation from that restructuring, but as part of it.

We believe that the long-term care redirection effort has not as yet effectively addressed the 10 steps. As a result, we are here today to tell you that we do not see the blueprint by which the overall process should be directed.

We are concerned that all of the activities currently under way—the long-term care policy framework, a document which we are now promised for later in March; the chronic care role study, which is still under way, final report pending; the conversion of chronic facilities to long-term care centres; and Bill 101—are not based on sufficient information to undertake the total direction of this sector.

This lack of information places in jeopardy the former minister's desire to ensure that a continuum of care is developed for all people eligible. Also, this lack of information will not allow us to address the issues that we have raised at the outset of this paper; namely, the relationships among care providers, determination of each facility's role, similar approaches to governance and accountability, and province-wide standards for long-term care.

1330

We then come to our recommendations. In order to ensure that redirection continues in a rational way, we recommend to you the following:

— That the enactment of Bill 101 be limited to only those aspects which are crucial to immediate administration of homes for the aged and nursing homes and payments to adults with disabilities to purchase services.

— That all items related to provider relationships, roles of facilities, governance and accountability, and standards of care be delayed for incorporation in the next piece of long-term care legislation, which the former minister has stated is to follow shortly.

— That in order to address the above, the government, as soon as the policy framework paper and the implementation plans are available, immediately consult with provider groups in a collaborative manner to discuss the adequacy of information in these areas to determine the process by which an information strategy can be established and the blueprint drawn up.

The OHA is following its own advice. We are planning a chronic care leadership conference for March 8 and 9 next where we will address the issue of information and the next logical steps in the process of developing a future vision for chronic care. We hope that our efforts in that conference particularly will be complemented by the government through it's pausing to consider with all of us together, all the major provider groups and the consumers, our strategic direction before proceeding with the long-term care implementation plan. We think we should be partners in that implementation plan.

Thank you, Mr Chairman. We will be happy to answer any questions the committee may have. I've referred to the strengths which I bring with me to handle those questions.

The Chair: Thank you very much for your presentation and for the specific recommendations. Let's move immediately to questions.

Mrs Caplan: Thank you for coming to the committee today with an outstanding brief, as always.

This morning I had the opportunity to ask some very specific questions about specific amendments. The line of questioning for this afternoon that I would like you to think a little bit about in your response to the committee has to do with the four concerns you have about what's going on and what's not there.

You've pointed out that there's no blueprint. If I were predicting, I would assume that since we've heard that March is going to be the time for the framework policy document, perhaps it will appear magically at your conference on March

8 and 9. I'm assuming the minister will be there, and that will be a good time for her to table and announce the policy; similarly, the chronic care role study, if it could be available, since they told us March at the same time. That might be—they don't think it's possible. So the two. We haven't got the blueprint. We don't have the chronic care role study information. We have Bill 101, and it's here after two and a half years of consultation.

The one that I'd like you to address for us, if you would, is the conversion of chronic care facilities to long-term care facilities. The OHA is very aware of that which is going on. I'd like you to share with the committee the information that you have. Also, has there been a clear definition of long-term care facility? And do you see any consistency or part of that blueprint vision that's taking place in the province?

I know there are many things that the individual facilities couldn't tell this committee, because of course they have to get up in the morning and work the next day. But as the umbrella organization, perhaps you could be candid with us as to some of the concerns you have about the directions that those conversions are leading us in.

Dr Dare: I'm very pleased to have an opportunity to address that. As you know, we only have the two concrete examples. You heard from the Perley Hospital this morning, and there's a similar conversion going on in the building of a new facility in Windsor. I think that the chronic care hospitals of Ontario have given more definitive consideration to this, keeping in close touch with developments, and therefore I'd ask Michel to refer to that and respond.

Mr Bilodeau: I have no definitive answer about what a long-term care centre will be. We heard through the grapevine that the government has already made up its mind about a number of facilities—we heard 10—a number of chronic care hospitals being converted into long-term care facilities. As this morning I tried to give you some specific examples of the results, I'll try with long-term care facility also.

John Lupton was telling me, for example—he came this morning but I don't think he addressed that—that what the new Perley will get for programs, and that's basically for professional services, will be \$3 per resident per day. I'd like to convert that to what it means for one of our hospitals, Élisabeth Bruyère, compared to one of our homes for the aged, Résidence Saint-Louis, because I have all the types of facilities. Right now, if we had \$3 per resident per day for programs, we would be able to hire five people. That's for physio, O'T, social workers, recreation, psychologists. We currently have 41 of these, compared to the five.

At the Résidence Saint-Louis, which is our home for the aged, we have three for 186 beds, compared to 41 for 225 beds at Bruyère. Maybe some people think there are too many at one place and not enough at the others. Maybe. When we consult the families and the residents, they tell us we don't have enough at the hospital. That means there are a lot of different things you do with these residents. That also means that in spite of what a lot of people say, the type of people who are cared for are extremely different, and I would certainly offer you to come

and visit the Résidence Saint-Louis and compare that with the chronic care hospital. These are two different worlds, and you just cannot do the same thing.

If we want to build warehouses for the elderly, fine, but we're not going to be able to rehabilitate them with that type of funding. Again, maybe I'm wrong. Maybe by coming down to \$185, as John mentioned, we're going to be able to do miracles with less money. I don't know. But quite frankly, I don't know how we're going to do it. We're very concerned about that because we don't believe—for example, we still don't have the results of the classification that was done last year. We don't know what the result is, so it's very difficult. How can we build a system without knowing what type of people we have in our beds?

Mrs Caplan: What I've just heard you say also is that the consultation that has been going on has been perhaps an exercise in talking heads, that information has not been shared that would allow for the meaningful collaboration as these new approaches are even taken or piloted or modeled. I have some concern about that because you've used the words "consultation" and "consult" as well as "collaboration," and that collaboration model is one of working together. Obviously, you haven't had the information that's required.

Mr Bilodeau: Well, I'll let Steve answer that.

Mr Stephen Skorcz: I would say the collaboration has not been there. I guess the way I view this process going is that to make any change of direction in the health care system, you really need more than consultation with the providers who deliver the care; you must make them partners in that change. And as we have spent the last six months trying to look at the roles of chronic care institutions, prepare them for the future and work in their vision, clearly one of the things we have looked at is these long-term centre developments. It is very unclear as to what information base there is as to what patients these will serve, and how well this has been identified.

I would also suggest that the Ontario Hospital Association, and I don't know if this has been purposeful or not, has seemingly been out of the loop in terms of the communication and collaboration on which—supposedly a number—of our members might become these facilities.

I'd say one example of this has been the policy and procedures manual that has been developed and has never been referred to the OHA for any review or comment. It is very difficult to work with our member institutions on a major issue which may confront them for the future when quite frankly we appear a fair bit in the dark about some of this activity.

Mrs Caplan: The framework document, the policy framework for long-term care that we're expecting in March—and I would point out for the purposes of Hansard that today is February 24—is it possible that document could have been compiled without the data and the information that you're saying is not available? I can't believe it's not available; in fact, it has to have been available for the policy document to have gone forward. That hasn't been shared with you?

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Mr Skorcz: If it has been available, it has not been shared with us.

Mrs Caplan: Do you know if it has been shared with your chronic care committee?

Mr Bilodeau: The members of the chronic care role study have had a copy of the manual, yes. But certainly those people who have had that in hand were, I don't know, instructed or otherwise not to share it. I know that someone from our home for the aged has a copy, and that's why I read the manual, but it has not been widely distributed.

Mrs Caplan: You mentioned the-

The Chair: Last question?

Mrs Caplan: Yes, last question.

You mentioned the concern that you have and that I think many of us also share in, this change to warehousing of people as opposed to the kind of support for care that a continuum of care would suggest, and rehabilitation make possible. In the planning of some of these facilities, there have been some concepts that I think are pulling at opposite ends and would leave one to be concerned that perhaps a long-term care facility will become a warehouse as opposed to an institution or a facility that would meet the needs appropriately.

For example, we heard that the institution here in Ottawa that was before us this morning is going to be dealing with the same population that they're dealing with today—a very high level, the highest level of care—and adding to that some medically complex procedures: tracheotomy, dialysis, that sort of thing. Yet in the original planning for that institution, it did not permit trays of food to be taken to the patients, but had a requirement that all patients have their meals in a central dining room with regular chairs and that kind of thing. I know that your association is familiar with that and concerned about it. Can you tell us, is that still what's going to happen in this long-term care facility?

Mr Bilodeau: Obviously, I'm not familiar enough with that, although when I hear what you say, sometimes I would laugh if it was not sad.

We have four beds for dialysis patients at Bruyère. These beds cost us \$175,000 per bed per year to operate. Now, if they want to operate these beds with \$185 per day, they're just not going to be able to. We're not throwing money out the window; we're trying to serve these people. Last year, the ministry gave us \$100,000 for four beds in addition to our regular funding, and we cannot make it. We haven't gone back to ask for more. We just said: "Okay, cost us \$135,000; we'll do it with that." That's not possible. You have to be out of the system to think it's possible.

The Chair: Thank you. Mr White.

Mr Drummond White (Durham Centre): A couple of questions, and I want to thank you very much for your presentation.

I'm sure, as you are aware, we're getting advice on both sides of the spectrum. This morning we had people saying, "Well, you shouldn't possibly be talking about institutions. You should talk about the community first," whereas your first recommendation is, essentially, let's deal with the

institutions first and when we have the rest of the package, we should move ahead.

But the issue about the quality and level of services is, I think, very important. You brought forth, Michel, the concern with \$3 a day and what that will pay for when you have social workers, occupational therapists and quality nursing staff.

I'm wondering about two things, and they follow from each other. My first question is, we've heard that in the homes for the aged and the nursing homes the level of care is increasing; the heaviness of the duties is increasing exponentially in the last few years. In fact, the average age of patients on admission now is higher than the average age of the residents in those facilities because of that exponential increase in the need of those patients. I'm wondering what your experience is in the chronic care hospitals. Is the same thing happening there?

Mr Bilodeau: Exactly the same thing. As the homes for the aged and nursing homes have people who require more care, chronic care hospitals have also been modifying their admitting criteria to admit people who are sicker.

Just a few examples: We have in our chronic care hospital 23 people on morphine right now, we have four on heroin, we have people with AIDS on AZT, we have people on dialysis, we have people who suffer from amyotrophic lateral sclerosis, and next week one is going to be on a ventilator and will require supervision 24 hours a day because there's nobody to take care of them at home. They can't go home. So of course our level of care has gone up also. It's a phenomenon. We have a two-and-a-half-year waiting list, so people get sicker and sicker.

Also, we now have rehab programs. That's not something that's not looked at, but we have, for example, people who have had an operation in an acute care hospital come in for four months to get intensive rehabilitation, go back to their homes and come in once a week for follow-up in a clinic. Out-patient clinics are not funded, but we fund them from our global budget because we need to. So of course, we face exactly the same reality.

Mr White: Following along those lines, specifically to the psychogeriatric and Alzheimer issues in chronic care facilities or for that matter any general hospital, you had some of the capacities, some of the resources to deal with that kind of clientele. I'm wondering if you perhaps have any knowledge of or experience in how generalized those resources are in the community.

Mr Bilodeau: It's difficult to say. In this region we have relatively good community services. We have, for example, a regional community psychogeriatric program, we have several memory disorders clinics, we have community-based home care programs for psychogeriatric patients, for Alzheimer sufferers, we have a couple of day-away programs for Alzheimer sufferers who remain in the community and we have a couple of day hospitals for those who require more care.

So yes, there are pretty good services, but we all face the same situation as the province is facing. That means budget freeze and numbers going up. So what was probably an

excellent service three years ago is now a good service and will be a poor service in three years' time.

Mr Wessenger: Thank you very much for your presentation. Staff would like to clarify some aspects about the comments that were made

Mrs Caplan: Why don't you clarify whether you are going to give them the information.

The Chair: Order, please.

Mr Geoff Quirt: With respect to the definition of long-term care facilities, I think it's reasonably clear that it's our intention, through Bill 101, to convert nursing homes and homes for the aged to what we call long-term care facilities. We now have separate acts, the Nursing Homes Act and the Homes for the Aged and Rest Homes Act, and hence there are different titles associated with these facilities. Our intention is to create a new, consistent program with consistent funding arrangements and provincial expectations for existing nursing homes and homes for the aged.

Mr Lupton was quoted as having said that \$3 per day would be available for programs at the Perley Hospital or the new Perley long-term care facility. I'd like to clarify that the commitment to the new Perley Hospital is to continue to provide all the funding associated with the Perley Hospital's budget now, to continue to provide all the funding associated with the Rideau Veterans Home and to continue to provide all the funding associated with the National Defence centre chronic hospital beds that will also be included in the new 450-bed Perley long-term care facility.

We do not see a reduction in financial support to the facility and, given that the funding associated with the veterans in the Rideau Veterans Home is at a considerably lower level, when you add all three pots of money together and divide that by the new number of beds, the per diem comes down. It's a question of mathematics, not a question of a reduction in financial support of the facility.

I'd also clarify that there are currently planning activities related to six long-term care facilities, chronic hospitals considering their future and opting to redevelop a part of their operation as a long-term care facility. I'd like to read off, just for the record, those facilities that to my understanding are planning in that regard: the Perley in Ottawa, Riverview in Windsor, St Mary's in London, a portion of Chedoke-McMaster, St Joseph's in Guelph and Riverdale in Toronto.

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In all these cases, the decision to pursue the development of a long-term care facility was a decision taken, as is the case with Perley, by the board of directors of the Perley Hospital and the other two facilities involved, and in all cases the result of some fairly extensive local discussions, as was the case in Riverview and in other communities to move in that direction. All these facilities have been given the option to await the results of the chronic role study before moving ahead with the redevelopment project, and these facilities have opted to pursue the development of a long-term care facility.

The long-term care facility manual is available to anyone who requests it. It's been provided to the members of the chronic role study steering committee and provided to over 40 provincial organizations for their review and comment. I'm not sure if the representatives from the OHA and the council of chronic care hospitals have shared that document with the organizations they represent on the chronic role study steering committee, but they're certainly free to do so. We'll be happy to provide additional copies if that's warranted.

Mrs Caplan: That's very helpful.

Mr Quirt: Every nursing home and home for the aged, I understand, has a copy of the manual from their association or from requesting it from our offices, so it's certainly a widely distributed document. A second draft is coming out shortly based on the input provided by those 40 organizations with whom we consulted.

I'd also like to clarify the issue of dining in the discussions with the Perley. It is our position that residents in long-term care facilities should have the option available to them to take part in a dining activity with other residents and engage in some social or recreational interaction at mealtimes. We do not support the notion that all people would be served all the meals for the rest of their lives on a tray in their hospital beds, and we obviously do not support the notion that people who are unable, for whatever medical or health reason, to move from their room to a central dining area would be forced to do so. It would be ridiculous to expect someone who could not take advantage of that opportunity to socialize and have a meal with a group of people—to force them to do so. There will be dining areas in numerous locations in the new Perley facility and, in keeping with the philosophy that long-term care facilities are people's homes for the rest of their lives, 75% of the people who will live in this facility will have their own private room.

Clearly, the long-term care division, with a tradition in long-term care services, and the people representing the Perley Hospital with a different tradition have learned a lot from one another in the planning process. As Mr Lupton mentioned this morning, while there have been disagreements, there has been some progress and there has been some movement towards the creation of what we hope will be a much better place for the people from the Perley Hospital and the veterans in both veterans' facilities to live in the near future.

The Chair: Any comment or further questions on staff's response?

Dr Dare: I don't think it's an appropriate time to go into the history of the differences that have had to be resolved. From the position of the Council of Chronic Care Hospitals of Ontario and the OHA, we are awaiting the additional information, which we have pointed out is not available. We do not have a characterization of the patient population which the long-term care division feels can be served in this new type of facility.

I think everyone will agree that the population at the Perley Hospital could not be looked after at the present time, except for maybe a portion of it. We do not deny that there may be a portion of, say, the patient population at St Vincent or the Elisabeth Bruyère that might be taken out of the global budget and put into a certain regimen of care with all of that involved: the staff mix, the specialized personnel and so on. These are the things we lack information on. I think we need that information before we can say that the new centre to replace the Perley Hospital will look after the patients who are now being served in any one of the chronic hospitals which may be targeted.

This is the sort of information gap we have before we can draw conclusions either on behalf of the Perley or on behalf of—and we question whether the long-term care division has had that information on which to base some of the things it is putting in fairly concrete fashion to guide the reform of long-term care and to implement it.

Mrs O'Neill: May I ask a question of staff to clarify one thing that was presented?

The Chair: I did recognize Mr Jackson first and then I'll go to you, Ms O'Neill.

Mr Jackson: I'll yield to Ms O'Neill, since I'm in her backyard, but I do with to get to the points I want to raise of staff.

Mrs O'Neill: Michel brought forward the point about the day programs and the outpatients. I just wonder, in this new level-of-care funding model, is there going to be any consideration of those kind of programs, because there's certainly a very different kind of budgeting than the global budgeting they're used to now?

Mr Quirt: Yes, there would be opportunities for that. For example, with the Perley Hospital, it's proposed that the Perley long-term care facility offer a day program for seniors and that the funding for that program be provided separate from and in addition to the per diem that's been mentioned for the operation of the long-term care facility.

Many homes for the aged in the province now offer community support service programs like day programs, meal programs or transportation programs. They are funded now, and will be funded, separately, and it's our intention to expand those programs with a portion of the \$441 million to be invested in community services.

The Chair: Mr Jackson.

Mr Jackson: I'm concerned that this process involves staff clarifying matters at length that shouldn't require being clarified either to this committee or to deputants. I wish to register with you, Mr Chairman, my concern that an increasing amount of time is being taken away from our inquiry and being utilized by ministry bureaucrats to clarify or put their spin on what's happening.

Having said that, I want to ask Mr Quirt if he was saying that the merging of nursing homes, homes for the aged, the varying acts, the varying funding mechanisms under a single piece of legislation with long-term care facilities—are we to take it then that we are pre-empting the chronic care role study and that in fact Perley for sure, and the five others that have been announced, are now going to become and be funded in a fashion similar to nursing homes and homes for the aged and that this is not going to be—I mean, if it's funded like a duck, if it serves the community like a duck, then it is a duck and it's no longer

a hospital. I'm quite concerned that we're not given an ample enough opportunity to explore this information. I want to ask the deputants about the number of beds that were surrendered in order to work out a deal with this government when I've been told—and we may as well get it on the table—that the attitude at the table was, "Well, we're going to get hurt badly if we don't roll over and comply with the rules of the game as they're now being constituted."

This process is going on behind closed doors, it's not being done with any knowledge of this committee and we have staff allowing those snippets of it to race across the floor and in Hansard as they see fit. I, for one, am very angry about the process. I'm hopeful that we will be given enough time to explore the meat and the potato of these issues. I want to be able to ask questions about bed losses. bed tradeoffs, the levels of care that are coming out of these discussions now that these decisions have been made. All we're being told is that we have no chronic care role study, but we now have six chronic care hospitals secretly negotiating with the government out of fear that the government might suffer them with some sort of retribution if the terms and conditions of those negotiations become public. It's wrong. Otherwise, this whole process is a sham.

1400

The Chair: If I might, before allowing Mr Quirt to respond to your questions at the beginning, it is 2 o'clock and I am concerned just in terms of what is a very full afternoon. I appreciate the points that are raised.

Mr Jackson: Mr Chairman, not to interrupt you, sir, but I sat here patiently without interrupting during about a 12-minute presentation by the government when the deputants didn't even ask the question. This is going on extensively. I would hope you'd respect our role as a committee. You do not accept calls for points of order, and no one's challenged you on that, but I think we have to be a little more fair in that we're a legislative committee in the process of listening to deputants and asking questions and not constantly have the government's spin on this thrown across the table for Hansard, the media and the public, which want answers.

The Chair: I appreciate that and I think I've tried to be very fair, both in terms of questions from members and also just what I would hope would be clarifications at times, which have then brought forward questioning back and forth. I'm quite prepared to allow some discussions. I simply want to indicate that we do have a very full afternoon. I'd like to ask Mr Quirt if he would respond, and if there is a further question or response from the deputants, I think then we're going to have to move on.

Mr Quirt: I'll try to respond as quickly as I can to Mr Jackson's questions. In terms of the Perley process, there were not beds surrendered to the government; I think there's an overall increase in the number of beds as a result of bringing those facilities together. I don't recall offhand how many new beds would be involved, but I could certainly find that out for the committee.

The planning process in these six communities has not been secret. It's involved the boards of the hospitals affected and other community players with an interest in the long-term care system. Certainly the Riverview project was the result of a long and quite open-process community report that recommended that shift.

Mr Jackson: My question, was, is the Perley Hospital now in the same category in this legislation as a nursing home and a home for the aged?

Mr Quirt: It will be when the new facility is constructed.

Mr Jackson: That's what I thought I heard you say and that's what's causing me some concern.

Mr Quirt: Yes, it will no longer be a hospital; it will be a long-term care facility. That's correct.

The Chair: Would any of you like to make a comment?

Dr Dare: I would like to say that we're very pleased Mr Jackson asked that question, because this has not been clear to us. When we see the draft manual on policy and procedures, which we have suspected was going to apply to these new long-term care centres, now we know how to approach it. As a member of the OHA—and I don't believe the CCHO has received that manual from Mr Ouirt for comment, not officially—we'd be most anxious to do so before it goes further. We are really quite concerned on the subject. You will be hearing later this afternoon from the Canadian Council on Health Facilities Accreditation. We're very concerned because it's really quite out of date, even in its terminology. It's still talking about quality assurance. We've gone long past that now. The concept and the principles are now involved with quality management and measuring outcomes, not, as that draft manual talks about, quality assurance. We are very concerned.

The Chair: I'm sure that manual will be made available to you. I believe there is a second draft we have heard about that is out or about to be out. I think that would be very important to you prior to your meeting on March 8 and 9.

Dr Dare: We would undertake an obligation to respond as quickly as we possibly can. Am I speaking for you, Stephen?

Mr Skorcz: Yes. I would just like to make an additional comment in the sense that I think it's important to remember that long-term care redirection is not solely the purview of those institutions that are identified as chronic care hospitals, but really of all hospitals in the province, because of the need to place patients in the community. I think a critical piece, though, about chronic care also easily forgotten is that of the 12,000 beds in the province half of those are in freestanding chronic care hospitals, but half of them are in acute care hospitals. In fact, one third of the beds in those hospitals identified as small hospitals—ie, under 100 beds—are chronic care; 92% of all hospitals under 100 beds have chronic care beds. This is a very important, pervasive province-wide issue. I'm not sure we have the information so that we can look at all these patients and all these designations with one single definition.

The Chair: Thank you. I'm sure we could probably spend the rest of the afternoon profitably. I regret, as the heavy in the chair, having to call this discussion to an end. You have noted your meeting on the 8th and the 9th. I think any results of that would be very helpful and useful for the committee. Again, I thank all three of you for coming and being with us this afternoon.

I next call the representatives from St Patrick's Home of Ottawa, if you would be good enough to come forward. Mr Hone?

Mr Hope: I've got a little bit of a concern here, because I'm looking at the times of presentations. We started at 13:16 and now it's 10 minutes after. We've allowed almost a full hour of discussion. I'm wondering how will we balance that out between the rest of the presenters, because Mr Jackson made a comment—

The Chair: I think if we could just get on with it, Mr Hope—

Mr Hope: There was a comment made by Mr Jackson on this, you know, taking away—

The Chair: No, I'm sorry. We've got to move on and I'm sure we'll—

Mrs Caplan: I have a question of the parliamentary assistant.

The Chair: No, please; I'm sorry.

ST PATRICK'S HOME OF OTTAWA

The Chair: Welcome to the committee. Despite our problems with the time, for which I take responsibility, you will have your full allotted time. We thank you very much for being with us. If you'd be good enough to introduce yourselves, then proceed with your presentation.

Ms Maureen Goodspeed: Thank you, Mr Chairman, members of the committee. I'm Maureen Goodspeed. I chair the board of directors at St Patrick's Home for the Aged in Ottawa. Sister Mona Martin is the administrator of St Patrick's Home.

St Patrick's Home for the Aged, founded in 1865, is sponsored by the Grey Sisters of the Immaculate Conception. Since that time, the home has grown from an orphanage and an asylum for the indigent to today's fully accredited, charitable long-term care facility for the elderly. Throughout its evolution, the element of loving care in a Catholic setting has been constant.

In 1979, St Patrick's Home was the first home in the region to become accredited. We are proud of our stellar reputation in the community, our leadership in the field of long-term care and our partnership with government and community agencies in developing a comprehensive response to the needs of seniors in the Ottawa-Carleton community.

The mission of St Patrick's Home states our commitment "to provide resident-centred, long-term residential and extended care as well as respite and outreach services to persons of all religious and ethnic origins." Underlying this commitment is the belief that all decisions, whether at the board, administrative, management or staff level, must be guided by an appropriate process of ethical reflection, rooted in core values within the Roman Catholic tradition.

Over its 128-year history, St Patrick's Home and the Grey Sisters have provided orphans, the destitute and now resident elderly with holistic care, including spiritual care. We believe that to ignore spiritual needs is as much neglect as to ignore any physical or social need.

St Patrick's Home supports in principle the Redirection of Long-Term Care and Support Services in Ontario. Several of the initiatives are positive, and we support the effort to bring consistency to the process and to provide a better opportunity for those who choose so, to live independently. However, we believe that Bill 101 fails to reflect the four principles the government has intended to guide the redirection. They include the primacy of the individual and the right to dignity, security and self-determination; promotion of racial equality and respect for cultural diversity; the importance of family and community; and equitable access to appropriate services.

I will address the areas of prime concern to us: the right of placement choice, funding and inspection.

1410

As a Catholic health care facility, we have a specific concern that consumer choice is not fully recognized in Bill 101. We strongly believe in the principle that individuals and families should be able to continue to choose where and how their elderly will live and be cared for: in an environment which honours the whole person, respecting spiritual, personal, social and cultural needs. The rights of individuals to choose accommodation based on the ethnic population or religious affiliation of the home must be considered as important in placement as other determining criteria. The right of choice is fundamental to the primacy of the individual and to human dignity. It is clear that this right is threatened in the placement coordination plan described in Bill 101, because it is based solely on a medical model. What is acceptable in determining admission to a short-term, acute care facility is not appropriate when considering long-term care.

Equally important are the rights of an institution to exercise some control over admissions. We believe that, guided by our mission, the types and levels of care provided by St Patrick's Home reflect a balance between the requirements of our community, both inside and outside the facility, and the limitations placed on us by physical design and finances. With only limited grounds to refuse placements, and with no guaranteed right of appeal, the ability of an institution to make firm decisions based on long-range plans is severely curtailed. The very character of institutions such as St Patrick's Home is threatened because the boards of directors would have no control over the nature of their institutions. Therefore, the community stands to lose precious resources.

Currently, seniors face no restrictions in choosing the care or services they require. Placement in a home for the aged is a traumatic experience for many people; it comes at a time in their lives when they may be facing a number of losses. In fact, placement in a home for the aged is usually precipitated by the loss of a spouse combined with the inability to function on one's own, advancement of an illness or even a major medical event. It is critical that seniors and their families be able to access services

through familiar organizations, including religious and cultural groups, which have a unique understanding of the special ends of their members, allowing them to provide appropriate and sensitive services.

The Residents' Council Association tells us, "Old age is a stage of human development, not a holding pattern or a time for withdrawal from society." People come to a home for the aged for the rest of their lives, not for just a few days or weeks. It is important that they maintain a sense of identity and control over daily life despite losses and change. The need to empower residents must be recognized in long-term care. Seniors should be provided with the supports they require to remain in their own homes as long as possible, but if that is no longer possible, it is important to recognize that facility-based care must be available in a way that takes into account different values, religions, languages and customs.

In terms of right of choice, we are also concerned that seniors who wish to live in a supportive environment and who are not deemed eligible by the service access coordinator and the placement review committee will be left with no other option than for-profit, non-regulated retirement homes. If this is so, the possibility arises that they will be left with few services and no protection.

The issue of funding is a serious concern for St Patrick's Home. For 12 years St Patrick's Home has had to contend with an operating deficit because of the acknowledged failure of our provincial funders to recognize the chronic and extended care provided by the home. In the last two years our financial situation has become acute. We and the ministry have lurched from crisis to crisis. We all know that the current funding doesn't work. We were told that a new funding system would support the care requirements of our residents. We were promised that the new funding would be effective on January 1 of this year. We struggled to meet our operating costs to that date, only to be told that there would be yet more delay, perhaps until January 1994. This is a completely unacceptable situation. It is time to deal with the reality of our budget problems now. Funding reform must take priority as a first step in the redirection of long-term care in Ontario.

The redirection must also recognize the outstanding contribution that various non-profit and religious communities, including the Grey Sisters, have made in meeting the needs of the elderly in our community, years of experience which must not be discounted.

Guided by a mission and not seeking profit, we welcome the development of standards. We do not appreciate, however, the powerful tool of inspection, the intimidation of sanctioning powers and the arrogance of immunity that the province has granted itself in Bill 101. For years, the provincial government has been our adversary in the effort to obtain better care for our residents through its failure to provide adequate funding. Historically, we have worked very hard to raise donations and recruit volunteers to provide quality care for our residents. Threats and sanctions are not necessary, and are inappropriate to a cooperative management model. They are a holdover from the time when jails and homes for the aged and nursing homes answered to the same director. Today, with the safeguards

of accreditation and public inspection firmly in place, we should abandon the outmoded, confrontational methods of earlier years.

In light of these considerations, I recommend:

— That all citizens, including the elderly, living in the province of Ontario be guaranteed the right to participate fully in the faith and cultural community of their choice.

— That a fair and reasonable funding formula be set up

and implemented without further delay.

— That a system be implemented whereby applicants' disagreements regarding admission and placement decisions be dealt with in a fair and consistent manner with a guaranteed right of appeal.

— That institutions be granted the right to appeal placement decisions through a process similar to that

which is established for applicants.

— That health care facilities continue to exercise choice concerning service referrals, age mix and retention of residential levels of care.

— That the local board of directors of the service coordination agency have equal representation from consumers, care providers and political appointees.

That the role of the local board of directors be

clearly delineated in regulations.

— That provincial guidelines be established for elections to these boards.

— That all regulations pursuant to Bill 101 be published and subject to debate before promulgation of the legislation.

We are very concerned that the principle of individual and family choice is being eroded, while at the same time the ability of boards of directors to make difficult and important decisions regarding placement and care is being diminished. As it is currently written, Bill 101 will destroy the freedom enjoyed by cultural, linguistic and religious organizations to provide the supports and services required by their members. It will destroy the very rights it purports to protect. Bill 101 must be revised to rectify these serious shortcomings, and the ensuing regulations must be brought under careful public scrutiny before the bill is enacted into law.

In the meantime, the actual levels of care delivered in charitable homes should be recognized and funded at least at the levels of the 1992 assessment to check the irreversible slide towards bankruptcy upon which we are now embarked.

Thank you, Mr Chairman.

The Chair: Thank you very much for your presentation. We'll begin the questioning with Mr Owens.

Mr Stephen Owens (Scarborough Centre): I'd like to begin by thanking you for your thought-provoking presentation. In terms of your financial situation, I'm not quite sure I understand how and why you've been—I don't know what the polite phrase is—jerked around for so long, and why it is now that you're being told that you'll have to wait, you say, perhaps until January 1994 for additional funding. Can you explain in a little bit more detail your comments?

1420

Ms Goodspeed: I'd be glad to. We have a 202-bed facility. Approximately half those beds are taken by people

who are extended care or chronic care level, but we aren't funded for that care. We provide the care because our people need it, but we aren't funded at the extra level that's required to meet our payroll. So we have been slowly—and it has been getting faster and faster as the years progress—slipping into debt. If we were being funded for the level of care which we provide, we would not have an operating deficit. It's as simple as that.

Mr Owens: Just in terms of your comments on page 7, again I'm not sure how this legislation is going to, as you say, "destroy the freedom enjoyed by cultural, linguistic and religious organizations." I'm not sure how this bill will do that, and in terms of what is happening currently in my own riding, for instance, in Scarborough Centre, that people are being devolved from hospitals into the community, there's not an opportunity to have that choice that you talk about in your brief. It's my view that while this bill is certainly not going to provide for a utopian society that we would all hope for in the care of our elder citizens as well as other individuals in long-term care facilities, again, in my view, it goes a long way to resolving some of the chronic concerns that have plagued the system. So I'm not quite sure how your view and my view could be so diametrically opposed on an individual whom we both care for.

Mrs Caplan: She doesn't share your ideology.

Mr Owens: I wasn't asking you the question.

The Chair: Let the witness respond.

Ms Goodspeed: Well, we run a Catholic facility. We're Catholic in our philosophy, our traditions, our culture, our practice. We run a residential facility and people choose to come and live there because they know, they understand, what kind of an atmosphere they will be living in. They come to live with us whether they're Catholic or not, but they appreciate the ambience that we have created there.

If people requiring long-term care no longer have the right of choice as to where they will go, then the residential mix becomes very, very different, and you could very easily have people being sent to St Patrick's Home because it was the only available bed who would much prefer to be at Hillel Lodge or would perhaps prefer to be in a home where only Cantonese is spoken as a primary language. You would not be meeting the basic needs of the people who are looking for a place to live in comfort and security for the rest of their lives.

Mr Owens: Just a quick question to ministry staff for the purposes of clarification. Maybe I don't quite understand the purpose of this legislation, but my understanding is that this legislation will in fact respect those cultural and linguistic needs that are out there, and that the element of choice will still be there. Is that a fact, or am I going down the wrong road on this one?

The Chair: Parliamentary assistant?

Mr Wessenger: Yes, I'd like to reply to that. Definitely it is a factor. The fact is, the whole aspect is for the placement coordination to work very much as it does at the present time in providing the choices for the consumer, and we don't see a change in that aspect of consumer choice. The consumers will make the decision as to what

institution they prefer or which one they want. Also, there will be provision in the sense that if someone has to go into an institution, on an emergency basis, that is the only bed available, they'll still have the opportunity to move to another institution. So that flexibility is built in, first of all, in the consumer choice in the initial institution you go into, and then with respect to the opportunity to relocate to an institution of choice.

The Chair: Mrs O'Neill?

Mrs O'Neill: Well, your reputation precedes you; you know that. I think it's important that I mention, because of the faith component of your facility, that you not only nourish and enrich the faith of your residents but, I think, of the families of your residents as well, and I know that from personal experience. I also know that you keep in touch with your families and consult with them as well as your residents.

It's a very strong brief you've presented. Certainly it's many of the things we've heard, but I don't think presented as forthrightly or as eloquently as you've done. You have hit on two items that I think are of very great concern: the January I date not having been met—we've heard that from several facilities, and facilities such as yours would be those that would be most concerned—and the confrontational model that seems to be part of this whole Bill 101.

There are some of your recommendations I'd like you to address a little more fully if you could. I'd like you to say a little bit more about the placement and the guaranteed right of appeal, which is your third recommendation, and then, if you could, about the role of the local boards and the election of those boards. I would find it helpful just to put a little bit more meat on those two recommendations.

Sister Mona Martin: Maybe I will address the placement, because we're primarily concerned with the placement. Although Bill 101 is saying that individuals will have choice with regard to where they go, I think the reality of the situation is that if a resident is in need and needs a bed today, he or she is going to have to take the bed that's available. The bed that's available could be a bed even outside the Ottawa-Carleton region, and that is even happening to some of our clients today. In fact, it happened to one of our clients yesterday where the family were very upset about this.

I guess the other aspect is that we're having a hard time believing that if people have to go into a facility not of their first choice, they are really going to get moved to the facility of their first choice eventually. The reason I say that is because at the present time, as Maureen alluded to, we have about 58 chronic care residents which we cannot get moved to chronic care. So the reality of us at the home is that it has not happened for us. We cannot get these individuals, who really should not be at St Patrick's Home because we're not funded for that level of care, moved to another level of care. I think that's where some of our apprehension comes from in terms of moving people.

The other aspect is that when people have to take a choice that's a second choice, the quality of life for that individual means many moves sometimes before they finally get back to the choice that they really made. If there are people who are in need, I don't think the individual who has already been placed is going to be taken out of the facility that he or she is presently in and put into a facility that now has a bed available. I think all of us realize that every day there are people who need to be placed. They are emergency admissions and they are the ones who are going to get the beds.

Maureen, do you want to address the other two?

Ms Goodspeed: Yes. You asked about the membership of local boards of directors for the service coordination agency. Our concern is to ensure that the care providers—the homes for the aged, the long-term care facilities—as well as the consumers, the families of the residents of such homes, would be adequately represented in that governing body.

Mrs O'Neill: It was actually your own governance that I was questioning about.

Ms Goodspeed: I'm sorry, I didn't-

Mrs O'Neill: Recommendations 7 and 8: the role of the local boards. Is that not your local board that you're talking about?

Ms Goodspeed: No.

Mrs O'Neill: Oh, I'm sorry. Okay, well, thank you for your very forthright and practical answer.

The Chair: Thank you very much for your presentation, for your recommendations and for coming before the committee this afternoon.

I'd like next to call on the Ontario Long Term Residential Care Association, if the representatives would be good enough to come forward.

Mrs Caplan: Mr Chairman, while they are coming forward, could I ask a short question of the parliamentary assistant?

The Chair: Yes.

Mrs Caplan: I've read this legislation and unless I've missed something, I can't seem to find the definition section where you define "long-term care facility." Would you tell me where to find it in this bill, please?

Mr Wessenger: I don't have the bill in front of me, but I'll ask legal counsel if there is any definition.

Ms Gail Czukar: I'm Gail Czukar, lawyer with the Ministry of Health. There is no definition of "long-term care facility" in the legislation because this legislation amends existing acts. It amends the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act, so the facilities are still funded under those acts and are still defined in those terms.

1430

ONTARIO LONG TERM RESIDENTIAL CARE ASSOCIATION

The Chair: Gentlemen, I want to welcome you to the committee, if you'd be good enough just to introduce yourselves and then please proceed with your presentation.

Mr Don Francis: My name is Don Francis. I'm the owner-operator of an 81-bed retirement home in Nepean.

I'm also regional president of the Ontario Long Term Residential Care Association.

With me today is Mr Alain Brunet, who is an independent owner-operator of a 72-bed residential care facility in Ottawa that provides 24-hour care to a mix of private-pay and subsidized general welfare assistance residents. The Brunet family has been delivering residential care services for seniors in the Ottawa-Hull area for the past 36 years.

Unfortunately, Mr Tom Howcroft was unable to join us this afternoon.

Mr Alain Brunet: Our purpose in addressing you today is to reinforce those concerns and to share with you our Ottawa experience in residential care. The Ottawa-Carleton region is one of the province's most active residential care areas, with more than 3,100 beds spread out across about 50 facilities. We believe that Ottawa has been a provincial pioneer in the provision of residential care services dating back to the 1960s. The fact that we have one of Ontario's largest concentration of beds and maintain an average occupancy level of around 90% speaks to a system that is quality-driven and highly responsive to the interests and needs of both our regulators and our consumers.

In Ottawa, we have a long-standing history of working closely with a full, long-term care and social service spectrum. Both private and public sector providers work extremely well together at all levels, including placement coordination, district health councils, homes for the aged, municipal governments and social services.

We address you this afternoon, fully confident that local representatives from Ottawa's public health sector would fully endorse our position that residential care is a vital component of the areas' long-term care delivery system regardless of ownership.

Specifically, we would like this committee to consider the impact of Bill 101 on the following areas.

The consumer's choice: We are very concerned that the issue of consumer choice would be severely limited when left in the hands of singular regional placement coordinators. We are especially concerned that as the sole assessment and referral source, the information available through placement coordinators will be controlled. If that precludes full disclosure of available residential care services, we feel the system will not be in the consumer's best interest.

We are equally concerned with the limited ability of applicants to appeal their individual placement decision by the regional coordinator. If choice is truly a priority in our new system, then consumers should understand all their options and have the ability to have input into final decisions that affect their personal futures.

Sensitivity to cultural diversity: In its current format, the bill is deficient in its recognition of Ontario's cultural diversity. Curiously, for us in Ottawa, this is most apparent in the lack of recognition of our francophone community.

The placement coordination role: Although the bill sets out a new placement function, there are no details as to how the placement role will be carried out. This cannot be left in the individual regions, where we're already witnessing area managers interpreting their roles quite differently across the province. In the public's best interests, this role must be defined clearly and consistently across all jurisdictions.

Lack of accountability: In the residential care sector, we have always lived with an accountability to our residents that is unique in long-term care. By moving away from an insured service to contractual agreement, it removes the government's responsibility to fund homes equally in order to provide the same level of service across the province. This is an open invitation for the government to treat facilities differently.

We wonder, given the proposed powers of the regional placement coordinators, whether residents in homes that are not treated equally will have an ability to vote with their feet in a long-term care system that dictates placement.

Long-term care is sharing up to a heavily regulated sector. From experience, we can tell you that a significant advantage for residential care has been our flexibility in meeting the changing needs of our residents, most often on a highly personal level. This flexibility has been in the vast range of building designs, amenities, services, programs and costs across our sector. Consumers benefit most when innovation is encouraged. We believe that a highly regulated system stifles innovation, personal attention and valuable consumer input.

Adversarial direction: The inspections, as described in Bill 101, appear to be adversarial. We do not believe that any purpose is served by inspectors having access to personnel records or records of any sort that deal with quality review activities, peer reviews or quality performance activities. We share the concern of our Windsor colleagues, who explained to this committee our problems with a revised long-term care system that excludes residential care services.

Mr Francis: Despite provider and referral recognition of residential services in the long-term care continuum for several decades, this committee should be aware that the Lightman commission has recommended regulations for our sector under the housing act, as opposed to a health or social services standard.

In Ottawa we have shared Dr Lightman's proposals with many of our residents and families. We note that across the professionally staffed retirement homes in this province, Dr Lightman held no consultation with our staff, residents or families. In fact, Dr Lightman admits that his study into unregulated accommodation was focused primarily on the lowest common denominator, for the most part involving boardinghomes. We cannot emphasize enough the difference between an all-inclusive, 24-hour, professionally staffed residential care program and a boardinghome. The two are as different as night and day.

As experienced operators and involved members of our regional and provincial association, we strongly support the need for appropriate provincial standards governing our sector. But applying a housing act with all its restrictions cuts at our very reason for being. This sentiment is shared by many residents and families, who continue to react negatively to Dr Lightman's highly restrictive approach.

Based on the Ottawa experience, we can also address another important aspect of long-term care which has received limited attention. Specifically, we refer to the needs of younger adults with chronic disabilities and post-psychiatric residents. This municipality has long been a leader in the development and ongoing management of a purchase-of-

service agreement that addresses the needs of this often-over-looked population segment.

The agreement between the local social services department and area home owners guarantees the rights of individual residents with respect to care levels, staffing, programming, diet, housekeeping and ongoing inspection processes. It is an agreement that has evolved through mutual understanding between the operators and the regulators and has been consistently driven by changing resident needs.

We urge this committee to review in depth the Ottawa experience as it relates to long-term care service delivery, the contribution of residential care within the continuum and the cooperative relationships that exist between both public and private providers.

In the best interests of consumers seeking quality, long-term care services, we sincerely hope this committee addresses a void that has existed since the outset of the redirection process: that retirement homes play an integral part in the continuum of services. In addition, we ask this committee to consider our recommendations specific to Bill 101.

We believe strongly that this committee's recognition of our suggestions and concerns will provide an optimum consumer choice, protection and quality service delivery. A long-term care system that formally recognizes residential care, offers consumers the full spectrum of options and pools the talents of both public and private sector providers will take us down a path of long-term delivery excellence, something that our aging population needs and deserves. Thank you very much.

The Chair: Thank you very much for your presentation and your recommendations. We'll begin our questioning with Ms Fawcett.

1440

Mrs Fawcett: Thank you for coming before us. This is certainly one area that leaves a lot of questions unanswered in a lot of minds, I think, and I guess mine is one of them. I think there are excellent retirement homes and they provide the services you have listed here. Then of course we hear there are some that are not up to the level of standard.

Right now you are not really regulated, and you mentioned just where you might fit into this or where you might not fit into it, and I agree with you that possibly there needs to be another set of regulations. While you are providing room and board, you are also providing other services, and in some cases medical services that would be available. I'm wondering if you could address just where or how you think you should be regulated, and also, what can we do with the homes that are not up to standard? I think the level of care required—some of the people who are coming into your retirement homes need more than just room and board.

I have a 94-year-old aunt in one of these facilities, and I know she is presently not getting, number one, even the diet that she requires. In so many cases you're not set up to provide the different kinds of diet available. And yet this was her choice, and I agree with you; there should be a choice there. But you want the best care.

Mr Francis: Our association had proposed draft legislation to define retirement homes and create a system of licensing them. Right now there is no specific provincewide standard. There's nothing defining what a retirement home is—defining it physically as a building, defining it from a staffing or any other point of view, really. We are subject to the building code, but that's it.

We're very concerned with Dr Lightman's proposal, because his second recommendation is to adopt the premise that a retirement home is principally a provider of accommodation and not care. In my experience, that just couldn't be further from the truth. People do not move into a retirement home for simple housing. In my own facility, people are paying approximately \$1,700 a month for a private room with a private bath. Meals, activities and supervision are provided. In our building, the last statistic I saw—on 73 residents, our nursing office is supervising 638 medications a day and the delivery and the consumption of those medications. People don't move into us for simple accommodation.

Mrs Fawcett: I agree.

Mr Francis: They stay in apartments for a fraction of the price, if they can.

Mrs Fawcett: Yes. That's the one reason my aunt moved in, because she didn't want to be alone in her apartment; she wanted the social—

Mr Francis: Exactly. Right. It's the socialization. I have a number of residents who are healthy, who take no medication. But they couldn't take being alone in an apartment and taking care of themselves totally.

The other end of the spectrum is the people who need the care. We have a lady now who has just gone to a hospital, who would actually be eligible for chronic care, coming out of our facility; her needs and requirements are such. Talking with the discharge planner at the hospital, it looks like she'll actually be placed in a nursing home outside the municipality, which is not very popular with the family.

People want the care. We need some standardizing legislation and the province needs it. Our association—

Mrs Fawcett: The draft report that you have, has that been presented to the government at all?

Mr Francis: We presented it to the government starting in 1985, I believe, and repeatedly advanced it. We hope they look at it and consider it. But the housing act, the Landlord and Tenant Act, the rent control do not contemplate care in any way or sense, so they will not have any impact on it other than to restrict it.

The Chair: Okay. Mr Jackson.

Mr Jackson: Mr Chairman, not being a fan of rent control, I can tell you that would be the worst thing, because in some instances it's just a guaranteed pass-through to tenants anyway. But leaving that for the moment, have you had any indication from the government, any discussions with the government that would indicate its willingness to examine the combination of accommodation and care components of your facilities and somehow finding an accommodation within the bill?

Mr Francis: In my personal experience, which is more limited than Mr Brunet's, in the meetings on the redirection

of long-term care we've been actively excluded, with them not wishing to consider us or think about us. The consumers and other providers at those meetings have actually asked why. I've seen them saying, "Why are they left out?" I appreciate that they had to draw a line somewhere. Beyond that, I'm not aware of any consideration, other than the Lightman proposals, to put any kind of regulation on rest and retirement homes.

Mr Jackson: I have an experience in my own constituency. I have some very outstanding facilities that are members of your organization. They are moving to condominiums, so that the condominium owners now have the right to determine that for this fee they will engage this kind of service. We haven't degenerated as a society to the point where what you own can be interfered with by the state saying, "I'm sorry; you cannot have a nurse on-site if you're prepared to pay her."

In the context of a condominium—I hate to draw the analogy—it's the same decision as wanting to put in an indoor-outdoor pool. There's capital expenditure, there's ongoing maintenance cost and there are probably staff involved. Where does the state get off stepping in and saying, "You can't do that," if the owners of the condominium in their collective determine that's what makes them a community, that's what meets their needs?

Mr Francis: In the meetings I've had with residents and family, the owners aren't the topic; it's the consumers saying: "Wait a minute. I have come to the decision that home care and other services do not fill my needs. I have freely chosen to purchase the service from you at cost to myself, at no cost to the government. What is the government doing saying I shouldn't be able to buy that service?" I've got 93-year-olds who are just jumping up and down about that. They are really upset that the government would propose to interfere with their right of choice.

Right now, in that sense, they say: "If the government is going to control it like that, whom do I complain to ultimately if my care's not right? Right now, Mr Francis, I walk in your door and I ream you right out if you're not performing. But if you're going to be in a position where you're going to say that the government says no, that I've got to obtain care services from non-profit, community-based services, whom am I going to complain to?" I don't know.

Mr Jackson: I know time is short, but I realize your residents' councils are a very vocal, active component that is—I know this is a dirty word—"market-driven." The fact is that the residents very much dictate the terms and conditions of operation and there's a certain empowering nobility to all of that.

Anyway, thank you for your presentation.

The Chair: Thank you very much for coming before the committee. Today, as I think you're aware, a number of your colleagues have presented as well. We appreciate very much your presentation.

Mr Francis: Okay. Thank you very much for the opportunity.

Mrs O'Neill: I'd like to ask the ministry staff, because both the last presenters talked about people having to go beyond the community of Ottawa-Carleton, which is not a small community—and I've asked this question previously—is there a definition now or a directive going to either the area offices or the residences themselves, placement coordination units, whatever you want to call them, about the definition of "community"? Because that's the term that's used, as I understand it, in the legislation. What is the interpretation of that?

The Chair: Meaning right now?

Mrs O'Neill: Right now and what is hopefully going to be proposed in the bill. Surely we're trying to get into a transitional model

The Chair: Very briefly, the parliamentary assistant.

Mr Wessenger: Yes, I'll ask some staff.

Mr Quirt: I don't recall that term specifically being used in the bill, but the placement coordination services now serve the same area that public health units serve or that district health councils plan for, and roughly half the people in the province have access to placement coordination services; the other half don't. But the idea is that regardless of where you live you would have access to the facility of your choice across the province, so that PCSs would have to work together to make sure those preferences were recognized.

1450

ONTARIO HOME HEALTH CARE PROVIDERS' ASSOCIATION

The Chair: I now call on the Ontario Home Health Care Providers' Association, if the representatives would be good enough to come forward. Let me welcome you to the committee. If you would be good enough to introduce yourselves, then please go ahead with your presentation.

Mrs Lucie Kean Frank: Thank you for allowing us time to speak. I am Lucie Kean Frank, assistant director of Bradson Home Health Care Services. I would like to introduce you to Claire Gonthier, the branch manager of Para-Med Health Services in Orleans.

We are members of the Ontario Home Health Care Providers' Association, which represents most commercial home care agencies in Ontario. Our members in this community operate through 11 offices with seven member agencies. Our agencies are, with one exception, Canadianowned and Canadian-operated.

We provide publicly funded home care at a rate that is 4.5% cheaper than the local not-for-profit. We do not incur a deficit for the taxpayers of Ontario to pay off and we must meet the same training standards as the not-for-profits but without going to the province, to the Ministry of Community and Social Services, for training grants. We employ almost 2,000 health and support service workers in this region. Almost all of them are women, many are visible minorities and many are francophones. Most of the managers in these companies are women and many of them are owners.

In Ottawa-Carleton we have closely followed the government's long-term care redirection. Association members attended all the public meetings held in this region and held one of their own with officials from long-term care. Questions to be discussed at the consultation

were sent to participants prior to the public forum. We can find no question on the government's stated preference for not-for-profit services in the French or English documents.

A summary report of the Ottawa-Carleton consultations states the concerns and recommendations put forward by participants. There is, again, no mention by consumers of a preference for a not-for-profit delivery system. Also, an OHHCPA director from Ottawa-Carleton was asked to take part in consultation meetings with provincial associations. Once again, there was no mention of the government's stated preference for non-profits. We wonder, then, at the government's continual assertion that this question was asked and answered by the public.

As recently as February 8, 1993, the Premier stated in a letter that a very comprehensive consultation process favoured the government's continued preference for not-for-profit services. In Ottawa-Carleton this question was not asked or answered in any of the aforementioned consultations

Also, I want to show you this booklet published by the government prior to the public consultations and sent to each area in the province. It's headed Tell Us What You Think. Again, there is no mention of commercial or not-for-profit service provisions. The preference for the not-for-profits appears to be government-driven for ideological reasons. In Ottawa-Carleton it is not the result of public consultations.

The Ontario Advisory Council on Senior Citizens published its annual report in October 1992. This body has a mandate to work in an advisory capacity only. Members are from a diversity of backgrounds and occupations. Most are seniors and all are active in their communities. It is interesting to note that in their review and recommendations on the consultation paper they make no mention of a preference for a not-for-profit service provision. They do, however, discuss the role of women in long-term care, and we support their recommendations. We know that the majority of primary care givers are women, and it is women, again, who will carry the responsibility of caring for those at home. It was recommended that any cost savings that may result from community care cannot be borne on the backs of care givers.

We have asked to appear before you because we have another major concern. Bill 101 is the first piece of legislation dealing with long-term care redirection. This bill controls access to facility care based on the premise that there will be more care in the community. But how can there be more community-based care when the government is planning to severely limit involvement of half the providers of home care services; namely, the commercial agencies? There is no plan or funding in place to expand community-based care to the extent that will be necessary to make home care available as an alternative to facility care.

This is a concern in Ottawa-Carleton where demographics show that the elderly population is growing faster than anywhere else in the province. The disruption of switching to a non-profit system would lessen the accessibility, the availability and the quality of home care as we have come to know it in our region. For example, there would be a loss of jobs at a time of high unemployment.

The cost to the taxpayer would significantly increase. The consumer would face a loss of choice and flexibility. It must be understood that if the government wanted to enforce a not-for-profit preference, no legislation or regulation would be needed to force our members out of publicly funded home care. In Ottawa-Carleton many of our member companies would be faced with bankruptcy and many employees would lose their jobs.

In closing, I would like to stress that there is nothing to be gained from a total preference for not-for-profit. We have in the past, and want to continue in the future, to work with that sector to provide quality home care with balance and choice for the consumer in Ottawa-Carleton.

Thank you. We can answer your questions in French or in English.

The Chair: Thank you very much. Merci d'être venus. We'll begin the questioning with Mr Jackson.

Mr Jackson: You obviously didn't read the NDP campaign manifesto of the previous two elections. It contained the consultation within their own party that there shouldn't be a preference for the commercial sector.

Mrs Kean Frank: Are you saying there shouldn't be or should be?

Mr Jackson: No, in its last two election campaigns it's been a cornerstone of the NDP's manifesto. At their last two party congresses they consulted with their own members, and I suppose that in the minds of the socialists that's enough consultation.

Mrs Kean Frank: That's right.

Mr Owens: That's not true.

Mr Jackson: It's the truth, Steve. If I wanted to be disgusting—

Interjections.

The Chair: Order, please. Mr Owens, Mr Jackson has the floor.

Mr Jackson: If you think that's a cheap shot, I could suggest to you that when your leader was studying in Cambridge he had occasion to walk down the hall and read the works of another learned scholar at Cambridge. It surfaced in Das Kapital.

The Chair: Okay, let's just direct our questions and answers

Interjection.

The Chair: Mr Owens, please.

Mr Jackson: That would be a cheap but true shot. Thank you for the interjection, and thank you for bringing some order, Mr Chairman.

Currently, the system works throughout the province in varying degrees. In some areas, that service which determines the amount of money to be allocated shows a preference. In Halton region and they openly suggest a preference. There are other regions where there is—and we've heard of this in particular in Thunder Bay, where it works very effectively—a balanced approach in the delivery of services. The two systems work in harmony. They are able to provide varying things so that at least somewhere there is care at certain hours of the day, instead of

everybody having to keep those hours. There's that flexibility in a tandem system. Just enlighten us, because we've had a bit of a snapshot, in terms of that level of cooperation and access or even differences in program delivery.

Mrs Claire Gonthier: First of all we are, as a private agency, able to offer 24-hour-a-day service, seven days a week. Some not-for-profit will not be able to provide that. That's the reason that usually they will come to the private sector. We have that flexibility. We are standardized in the sense that we follow regulations from the government. We have followed the salary requirements established by the government. When we go to submit a proposal for being a provider of care, we have to go with the requirements established. I think that in this particular region we have been able to work in harmony with the not-for-profit sector and I think we can continue to do so. I think we play a valid role and an important one that the consumer and the client would be missing if it were going to go only for the not-for-profit.

Mr Jackson: Thank you for that. I certainly can only suggest to you that it's the position of our caucus as Ontario Conservatives that we see diminished access in a single-source system and that patient choice and consumer choice is a right and a protection for the consumer from governments which change in both their philosophy and their levels of compassion. So I thank you for your presentation.

Mr Wessenger: Thank you for your presentation. I'd just like to indicate that a long-term care consultation paper was distributed, about 89,000 copies. It stated the government's preference for not-for-profit, so I just wanted to clarify that certainly it was well out there publicly.

Perhaps you might enlighten me with the percentage share of market you have for both home care and nursing care in this area—if you could indicate.

Mrs Kean Frank: Home care and nursing care?

Mr Wessenger: Yes, the two areas in the Ottawa region.

Mrs Kean Frank: We do not provide any nursing care in Ottawa-Carleton. The visiting nursing program you're talking about?

Mr Wessenger: Yes.

Mrs Kean Frank: This is provided by VON exclusively here in Ottawa-Carleton.

Mr Wessenger: So you're just talking about home care alone?

Mrs Kean Frank: We're talking here about homemaking services.

Mr Wessenger: Homemaking only? Right.

Mrs Kean Frank: And we are very concerned that we'll be in business—

Mr Wessenger: Perhaps you could indicate to me how much. Do you know what percentage of the market you have?

Mrs Kean Frank: Here in Ottawa-Carleton I believe close to 25% is not-for-profit.

Mr Wessenger: And you have about 75% of that.

Mrs Kean Frank: Yes, it's divided between 11 agencies.

Mr Wessenger: Fine. Thank you.

Mrs Caplan: I'd like to discuss with you your role and participation in the consultation that the government has said has been comprehensive and widespread over the last two and a half years. Has your association ever requested a meeting with the minister?

Mrs Kean Frank: Yes we did, with Minister Lankin, but we did not get any meeting. She refused.

Mrs Caplan: She refused to meet with you?

Mrs Kean Frank: Yes.

Mrs Caplan: Did you write to the Premier, asking if he would get a meeting for you?

Mrs Kean Frank: We lobbied; we sent a lot of letters. We also consulted our employees as well, because that will affect them, that's for sure. The Premier has been replying with a letter, saying that—actually, I have the letter here that he had sent to some employees. Can I read it?

Mrs Caplan: Please.

Mrs Kean Frank: He says: "We undertook a very comprehensive consultation process to restructure Ontario's long-term care system. Prior to the consultation we stated our goal of continued preference for not-for-profit services in the delivery of government-funded home care. Our consultation did not indicate that there is a feeling that we should change this direction. We are now looking at how not-for-profit services can be put into place over time without disrupting current service."

Mrs Caplan: Do you know of a direction that's been given by the minister in regions across the province without legislation, just by policy.

Mrs Kean Frank: I know that in November we received a formal memo from home care telling us that all the new cases will be given to not-for-profit. We realize the impact it has on us as well.

Mrs Caplan: And you've had no meeting with the minister or opportunity to discuss this?

Mrs Gonthier: No, we've had no meeting. We were told as an association that the Minister of Health at the time was told to meet with us. It wasn't done.

Mrs Kean Frank: We were told also that we are chasing shadows—

Mrs Gonthier: That is not really true, what they're planning to do.

Mrs Caplan: Could you explain that?

Mrs Kean Frank: We were told that we are chasing shadows, that there's really nothing official that came to tell us we're going to be out of business. But, as I said, they don't need legislation, they could just kind of gradually assign all new cases to the not-for-profit and very shortly we'll be out of business.

Mrs Caplan: And you've been told that's happening already.

Mrs Kean Frank: It is happening now, yes.

Mrs Caplan: I'm aware of a meeting that took place between representatives of your association and a policy adviser from the minister's office and the Premier's office. Are you aware of that meeting?

Mrs Kean Frank: Yes.

Mrs Caplan: It's my understanding that your representatives were told there was no place for the private sector in the delivery of services, is that correct?

Mrs Kean Frank: They want us out of human services.

Mrs Caplan: Say that again, please?

Mrs Kean Frank: They said they want the commercial agency away from the human services.

Mrs Caplan: And this is from the same government and the Premier who in a speech yesterday said that all the labels—that they'd reconciled the left and the right and that they were working cooperatively with business; they were no longer anti-business, private sector. Did you read about that speech?

Mrs Gonthier: Not yet. The Chair: Final.

Mrs Caplan: I guess the concerns I have are that, one, you're not being listened to. You provide an important service. We have always believed, and I believe personally, that what's important to the people of this province and to the taxpayers of the province is that they have the highest possible quality service at the best price. What seems to be important to the government, its ideology, is more who's providing the service than the result of the service it's providing.

Mrs Gonthier: The cost-efficiency of the service should be a big factor right now with the big deficit we're facing. We are taxpayers as well.

Mrs Caplan: Best service at best price rather than publicly run, government-run services, and you see us moving towards a broader public sector, regardless of what the expense is.

Mrs Gonthier: What the cost would be to thousands of jobs, specially women.

Mrs Caplan: And you're worried about that as private sector employers as well as the taxpayers of this province?

Mrs Gonthier: Definitely.

Mrs Caplan: I share your concern.

Mrs Gonthier: Thank you.

Ms Carter: Do we have any more time?

The Chair: I'm afraid we don't. I want to thank you both for coming forward. J'aimerais vous dire aussi: vous avez exprimé vos remarques en anglais et, si je comprends très bien, vous êtes francophones. Alors, laissez-moi vous remercier de votre participation cet après-midi.

Mme Kean Frank: Merci.

Mme Gonthier: Merci beaucoup. Thank you.

KANATA BEAVERBROOK COMMUNITY ASSOCIATION

The Chair: I now call on the Kanata Beaverbrook Community Association, if they would be good enough to come forward. I should have said the representatives of the Kanata Beaverbrook Community Association. Welcome to the committee and if you would be good enough to introduce yourself and then please proceed.

Mr Fred Boyd: Yes, I was going to say I'm not the association. My name is Fred Boyd. I happen to be the president of the Kanata Beaverbrook Community Association and chairman of what we call the Joint Committee of Community Associations in the city of Kanata.

I wish to say that this brief has not been approved by the entire association. It has been reviewed by the executives of both groups, but I wish to take full responsibility for the actual words and so forth.

The Chair: What's good belongs to everybody and what doesn't belongs to you.

Mr Boyd: Something like that, yes. I really dislike reading a brief or a paper, but I understand the difficulty here in that you have not had a chance to read it ahead of time. I will do as I think is the practice here, essentially read it, dropping out a few things and perhaps injecting a few points along the way.

First of all, thank you very much for the opportunity to speak to you on this important issue. I guess a bit of a background to comment meaningfully on this bill is really necessary to look at the objectives of the bill and basically what it's trying to do. That includes a couple of basic questions of what are the objectives and does the bill appear to fulfil the objectives or part of those objectives.

As far as the objectives go, we have seen the consultation paper, Redirection of Long-Term Care in Ontario—I think that's the title—and in some sense, we feel we should have been commenting on it, but if there was an opportunity to comment on that consultation paper, we missed it. So we're taking this opportunity to come forth. I will try to keep our comments as much as possible on the bill even though, as I say, the context is important.

1510

I also heard yesterday one of your members mention that there is a policy paper forthcoming, or being promised in the near future. Just a quick aside, I find it rather sad that the bill comes out before the policy paper, but that's just a quick injection.

Going back to the background, as I mentioned, I am the president of the Kanata Beaverbrook Community Association and chairman of the joint community associations of the city of Kanata. Kanata is a satellite city in the western part of this region—satellite in the fact that it is outside the greenbelt and therefore significantly more separated and, I guess I might say to some degree, independent than the typical suburb. In that regard, we have a significant commercial and industrial base which provides employment for about half of our working population, or equivalent to about half our working population.

As I mentioned earlier, the brief has been reviewed by many people—the executive of my association and people representing the other associations—and has tried to incorporate essentially all of their comments, but the words are actually mine.

To some extent, just to open a point here, it's a bit of a companion to the personal account by Lesley Cluff last

evening. Mrs Cluff is a member of our association in the community. As you heard, I think it was a very eloquent, personal explanation and presentation of what we know many people in our community are facing and hers is perhaps more extreme. I was pleased that she was prepared to come forth and give you that personal account.

The Beaverbrook community in Kanata is the oldest part of Kanata and that reflects one reason why I'm here. Kanata itself is a young growing city and, as a net result, has a younger population distribution than the average in the province. Our particular community, which has been established, was begun about 27 years ago and has been sort of fully established for almost 20 years.

In my perception—we don't have the actual figures—it is closer to the provincial average. We have a very significant number of elderly people in our community and our community association reflects that. That is one reason I'm here speaking because this topic has come up several times within our monthly meetings and other arenas, should we say, and there have been repeated concerns about the direction of long-term care.

Jumping over some of that material on Kanata, I'll turn over to page 3. Despite an obvious need, in particular in our community, we do not have any of the long-term care homes being specifically addressed in this legislation. In Kanata we have two retirement homes which provide extended care. I'll be coming back to that particular topic later. Also, we do not have any hospitals. We are now a city of 40,000-some and we must depend upon the Queensway-Carleton Hospital in the western part of Nepean, which is some distance away, and which many of us are concerned about because it has not been allowed to expand at all even though it—I think they call it the catchment basin—has expanded by at least a factor of three or more since it was opened.

A particular point about Kanata is that it's surrounded by a rural area. There's a rural sector in the city and it is contiguous to two rural townships, Goulbourn and West Carleton for which Kanata serves as the focal point. A specific expression of that, in this context, is the community resource centre of Goulbourn, Kanata and West Carleton which provides social assistance for this whole area.

The centre offers a number of services: crisis support, abuse counselling, community support and is a source of information for many of the services that have been referred to in your hearing. In a particular regard in this area, it does provide Meals on Wheels and also transportation services for seniors and the disabled to go to medical appointments and so forth.

As a quick aside here, that presumes the elderly and the disabled are able to make the arrangements for such appointments. I would suggest that comes back to a little bit of the question of psychological aid, which was referred to by a presentation last night.

Now, getting specifically on to the bill, in my eyes—and I have been involved with legislation, regulation and so forth at the federal level over the years—Bill 101 appears at first glance to be what I would call housekeeping. In other words, it's reworking a number of other laws. It's very, very difficult, even for someone as familiar with legislation, to grasp its

contents and its real intent. My own view is that it would have been far better to have scrapped certainly the three key acts on old-age homes and so forth and come up with a brand-new one.

Just reviewing the points which according to the compendium are the points which are being addressed in this bill and which you can determine from a close reading of it, these are the ones that I will be addressing as to our judgement as to how it affects that, and then we'll try to deal with a couple of comments on what the bill does not address.

The bill proposes a consolidation and harmonization of several types of long-term care homes. It establishes a funding system based on the level of care and the creation of placement coordinators, the provision of rules for payment by residents and the requirements of formal accountability and quality assurance programs and the enabling of direct funding for disabled adults.

My comments, as I say, will deal with these particular headings, and just going back to what I just said a moment ago, my personal feeling is it would have been far better to have come out with a brand-new act rather than this extensive modification which is, as I say, very, very difficult to deal with and to read and to fully grasp. I'll now go on to the specific points.

Consolidation: I'd say that given the variations in the various types of long-term care facilities in the province that any of us have been involved with, there's no doubt that this is a very positive move, and we support that even if, as I say, the mechanism appears to be cumbersome.

The funding: The level-of-care system and the service agreement concept that goes with that again seem reasonable, but we're left with a problem that all of the details—the criteria, the guidelines and so forth—are left for regulations. I've been involved with the development of regulations. As I say in here, regulations are typically developed by officials and, in our experience—I presume it's the same at the provincial as at the federal level—quite often reviewed only in a perfunctory manner by cabinet or their agencies, which leaves no input for those affected by the regulations. The regulations will be what affects people, and not the enabling legislation.

Our first recommendation is that proposed regulations be issued for public comment before being put into force.

1520

On the access to the facilities, the concept of a placement coordinator is presented. There have already been several comments to you on that and I'm sure you have heard it in other localities as well. We are quite concerned. This appears to be an almost heavy-handed situation, if you want to call it that. As I've said, there does not appear to be any allowance for local input into the selection or appointment of the placement coordinators or local involvement in the decision-making process. While this may provide some province-wide uniformity, it does ignore local conditions, disregard what we would consider to be a legitimate role of the local community and, for many of us, imply what I would call a Big Brother approach, which we find demeaning.

When you add that to the words in the consultation paper on redirection of home care and support services that there be no more beds for long-term care for several years, and put that in the context of the rapidly growing elderly population, we can see that there will be a very much of a backlog here, a real bottleneck. We have the fear that these placement coordinators will then have to be applying what I will call draconian rules to restrict access. Then you add to that the appeal mechanism, which in our mind sounds very cumbersome and bureaucratic and to me, because I've been through this, suggests a process similar to the Ontario Municipal Board, which is not easy to use.

We have several recommendations coming out of this:

We propose that the legislation should allow municipalities or community health groups or other appropriate bodies to have an input into the selection and appointment of the placement coordinators.

We recommend that the province provide guidelines for access that would be used by these placement coordinators and make these guidelines available for public comment prior to them being put into force, and that the appeal board should be at least established regionally to make the mechanism easier for people to make the appeal. In the situation where there are expenses involved, we suggest that the legislation provide or allow for the compensation of expenses by applicants, by people making appeals.

We then make our last plea, that there really should be an expansion of long-term care facilities. I'll come back to that perhaps in final comments.

The enabling legislation for payment by residents appears to be a reasonable approach. Again, the concern we have is about the specific regulations and also the effectiveness of the inspection that will ensure the level of care for which the funding is actually provided.

As above, we would recommend that proposed regulations in this context be issued for public comment prior to them being put into force, and that adequate and effective inspection be put into place. I'll come back to that in a moment.

On the broad question of accountability and quality assurance—and I would add to that inspection—the bill requires facilities to provide financial records for inspection, to post financial information and to prepare quality assurance plans. It also provides for enhanced inspection powers, which I was pleased to see.

I'd say this is an excellent provision at the legislative level, provided the regulations are put into effect properly and, even more so, provided they are actually carried out. Our concern is that effective inspection requires an adequate inspecting staff and sufficient qualified inspectors to do so. Our concern is that with the current budget restrictions, it is quite likely that this will not come about. Therefore the bill will be what I would describe as a paper tiger, having wonderful provisions but not actually being carried out.

Just as a quick aside, I'd make the comment that we would hope the bill would not preclude—and it does not appear to do so—unannounced inspections. I've been in the regulatory business and I can assure you that unannounced inspections are an essential component if you really want to have an effective inspection program.

Our recommendation is that the bill should stipulate the extent of inspections and a minimum number of inspections per year. I say this because this could put an onus on the government to ensure that the inspection capability is actually provided and that inspections are actually carried out. Also, our suggestion is that inspection reports be made public. In addition to the posting of the financial information, I think any inspection report should be posted also.

On the question of funding for disabled adults, just a very quick point. This just sounds like a very desirable move, and no comment on that other than to say that there is also the question of psychologically disabled people. The bill is silent on that, but that's perhaps a completely different topic.

There are a number of areas which are not specifically in the bill and therefore you have to either infer or look for them or look for what is missing. One of them is that we feel there is a definite need for standards for and inspection of home care services. If you're going to go to a system where you're going to have more people staying at home, more people depending upon the home care system, then that system must be regulated to an equivalent degree to the home care facilities.

In essence, we would ask that the bill be modified to require the issuance of regulations governing the qualifications of home care professionals and the standards of home care service, with some provision to allow inspection of those services.

The bill is silent on retirement homes. I was interested to hear the presentation or two before mine, and interested to hear that those operators of retirement homes seem to be prepared to be regulated. In our mind, retirement homes are very much part of this spectrum of long-term care facilities and, as such, should be regulated to make them consistent with the other parts of the system.

There has been considerable mention of for-profit and not-for-profit facilities. Our feeling is that we see no reason why one or the other should be excluded. The primary need is effective care for the people who need the care, and as long as there is an effective regulatory system to ensure proper standards, an effective regulatory system to ensure fair payments, fair costs, then in our judgement there is no reason why you shouldn't have both forms of facilities.

1530

Just as a quick aside, I noticed that in the compendium accompanying the bill it stated that the payments by residents would be based upon, where there is an association with ability to pay, income and not assets. I don't see that any place in the bill. It seemed to me it should be in the bill and not just in regulations.

Our basic recommendations are that there should be provision for regulation of home care services and the professional personnel of those services and that they should establish a regulatory regime for retirement homes.

Just to summarize what I've said to date, I mentioned that we feel that the particular form is cumbersome; there is a need for local input into the appointment of placement coordinators; there is a lack of information at this stage on the criteria, rules and all the regulations that go with that; there is an absence of mention of retirement homes; and

there is an absence of provision for regulation of home care services.

To summarize our recommendations, we recommend that the proposed regulations under the bill be issued for public comment prior to being put into force; that there be provision for local communities or municipalities to have an input into the selection and appointment of placement coordinators; that there be a requirement that the guideline for access be issued for public comment; that the bill include a stipulated minimum inspection frequency for all long-term care facilities; that there be a requirement that the inspection reports be made public; and that there be a provision for regulations governing the standards of home care services and qualifications of home care professionals. Further, there should be legislation, whether it be in this bill or not, to cover retirement homes. Finally, our last plea is that additional home care facilities be provided.

If I may just make some final remarks, our real concern is the policy behind this bill. The Redirection paper states bluntly that there will be no more long-term beds created and the bill, as I say, appears to reflect this without stating it explicitly. The argument for not providing more long-term facilities is that most people would prefer to stay at home. Our attitude is: Of course, if you ask people, that would be the answer. But we would say that this ignores what we would call the pressing demographics. The number of people over 85 is increasing by 4% per year according to Statistics Canada and that rate of increase is increasing itself, so you've got an exponential growth here.

A high percentage of those in that age group are now institutionalized. I would suggest our feeling—not just my own—is that this is not due to callousness on the part of the family, as has been implied by some, but rather generally because the family, where there is a family, is unable physically, psychologically, financially or otherwise to take care of its elderly relatives at home. This would apply even if home care services were augmented. I might say, just as an aside, that I've been very disturbed, speaking to many different agencies in the area, that there doesn't appear to be any real sign yet of a significant increase in funding for home care services.

If you'll permit me just a personal note, I have an elderly mother in a nursing home in Burlington. She's there because there is absolutely no way that either my sister, who is older than me, or I could look after her. We don't have the physical strength, the mental fortitude, as I put it, or the facilities, as Lesley Cluff mentioned last night, to do so. I know of many who are in the same boat. I know of several people in our community who are actually trying to look after their elderly relatives, either their spouse or their parents and so forth at home, and destroying themselves and their family in the process.

For a government which avows its concern for social justice to use the results of what I would call a questionable opinion poll or a fine-sounding but abstract principle—ie, that the elderly should stay at home—as an excuse to save money by refusing to provide more desperately needed long-term care facilities raises thoughts of cynicism and hypocrisy.

The move to harmonize the laws governing the various types of long-term care facilities is laudable. We support

that. However, if there's no action to increase home care and community support services and no willingness to recognize the rapidly growing elderly population by creating more appropriate facilities, this exercise could be described as a legislative shuffling of the chairs on the Titanic while the ship of long-term care sinks in the icy waters of budget restraint. Pardon me for the flowery words.

The Chair: Thank you very much for your presentation. We are tight on time, but I will allow one short question per caucus.

Mr Villeneuve: Mr Boyd, thank you very much. You've touched on a number of things that are very important in parts of rural Ontario, in West Carleton and Goulbourn, as they apply in your area. Meals on Wheels, transportation, medical and legal appointments are most important to those elderly people out in rural Ontario. I think it's been found in other areas that whenever the private sector has moved out and it becomes delivered by the public sector, we tend to lose many of these volunteers. Could you comment on that? Because I know your community association is very much a group of volunteers. We also had a presentation this morning by the regional municipality of Ottawa-Carleton with very alarming results: the population and demographics and a number of other things that touch your neighbourhood.

Mr Boyd: May I just ask, was that the one from the homes for the aged group of the region?

Mr Villeneuve: Yes.

Mr Boyd: Yes, I'm aware of that one. I have been in contact with them.

I'm not quite sure whether I caught the flavour of your question. First of all, our community resource centre is staffed by a small number of paid professional people, but much of the work is done by volunteers. It is a not-for-profit operation. I suspect the volunteers would be less willing to volunteer for a private operation; in fact, I think I can express that fairly strongly. The volunteers seem to prefer to help not-for-profit organizations. I'm not sure whether that's the answer you wanted or not, but that's my view and that's the situation.

Mr Villeneuve: Your comments are well taken, but I think the word "not-for-profit" is misleading. The people who preceded you here are private sector deliverers of service for about 5% less than the so-called not-for-profit group. We have to remember that the "not-for-profit" connotation tends to be a little bit misleading at times.

Mr Boyd: As I mentioned earlier, we certainly, in the broad sense, have no feelings for or against. In general, we'd say we support the private involvement as well as the not-for-profit involvement.

The Chair: Ms Carter? Again, if we can just be brief.

Ms Carter: You certainly covered a lot of ground, so I'd just like to make a comment and then a question. First of all, you say on your page 10 that the government used "the results of a questionable opinion poll" as a basis for trying to keep more people in the community. I'd just like to say that there was a most incredibly extensive consultation process with the public and all kinds of interested

groups. I forget the actual numbers as to how many people participated—

Interjection: It was 75,000.

Ms Carter: —75,000, and the number of briefs. The government issued a document and people commented on it and so on. I don't think it was a questionable opinion poll. I think there was a lot more to it than that.

But what I really wanted to ask you was that we've had a lot of presenters at this committee saying that they didn't like the suggested inspection process. You seem to be in favour of that. Just as a matter of interest, I wondered whether you felt that the other checks and balances that will be in place are inadequate. For example, each resident will now have an agreement as to what care is to be provided to him, and if that is not lived up to, presumably he can complain or call an advocate or whatever. There are residents' councils, not in every institution, but again, that's fairly widespread. Then there's the system of accreditation that was mentioned, I think, several times this morning, whereby institutions are inspected and, if they're accredited, then presumably they shape up. I just wondered if you'd like to comment on that.

1540

Mr Boyd: I know the Chairman is short on time and I'll try to be quick. First of all, I would say that the resident agreement system was not adequate. I really firmly believe, both from a personal point of view of a background in regulation and also involvement with and reflecting other people in this area, that you do need an external inspection service. If you had something you called accreditation, if you had that system applied throughout the whole regime, through all these homes, including the retirement homes I mentioned, to me that's part of what I would call this regulatory inspection system. I think both are desirable, but I would strongly urge that you do need a good regulatory inspection system.

Mrs Fawcett: I was really interested in your idea that rather than amending the present three acts we should move to a brand new one. Having heard the other presenters before you, I'm just wondering if possibly then we could include chronic care hospitals and retirement and rest homes and do the whole thing all in one brand-new bill.

Mr Boyd: There's no doubt in my mind and in most of the other people who have reviewed this with me that this is the way we feel, that it would be far better to first of all have a clear policy laid out and then a brand-new act which would then replace these various acts which are around at the moment. At the moment you will have a very odd situation. You'll have this amendment act and you'll still have all of the other acts sitting there. It's going to be very difficult for anybody to keep track of it all.

Mrs Fawcett: Just around the ideas you put forward on inspectors, we've heard many, many presentations saying that the inspector idea is punitive and there is resentment built up. Rather, we have gone past that and gone to quality management and improvement measures and residents' councils help out and all those kinds of things, as long as the assurance is there.

Mr Boyd: I've been through that, and even if you have a so-called quality assurance system, you have to have a good audit of that quality assurance system, which is almost the same thing. It's not quite the same—the technique is slightly different—but you still need this external regulatory overseeing, if you want to call it that.

The Chair: Thank you.

Mr Boyd: I apologize for being longer than I—

The Chair: Not at all. We thank you very much, and also those who worked with you on the presentation. Thank you for coming.

Mr Boyd: May I just say very quickly—I didn't say it at the beginning—that our objective was just to come in as a completely—what do you call it?—disinterested body. In other words, we're not in the system. Our only concern is our own elderly residents. I've been slightly concerned to see that three quarters or more of the people speaking to you are coming with what I'll call a fixed agenda. I know you'll all be able to weigh all that and sort it out. Thank you.

The Chair: With the wisdom of Solomon.

Mr Jackson: That stands for the members of the committee as well.

Mr Boyd: Oh, yes.

COUNCIL ON AGING-OTTAWA-CARLETON

The Chair: I call our next witness, the Council on Aging for Ottawa-Carleton, if you would be good enough to come forward. Welcome to the committee.

Mrs Sylvia Goldblatt: I'm just going to pour myself some water.

The Chair: Yes, please. I wonder if we need some more glasses. We'll just check and see whether you need some more water as well. We want to thank you very much for coming to the committee. If you would be good enough to introduce yourselves, then please go ahead with your presentation.

Mrs Goldblatt: Thank you very much, Mr Chairman. I'm Sylvia Goldblatt. I'm here as one of two vice-presidents of the Council on Aging. In some ways, I represent an example of a 70-year-old consumer who is delighted to have the opportunity to participate in this discussion.

I realize your time is short, and I'll get to my brief. I would just like my colleague to have an opportunity to introduce himself and give you some feel for the Council on Aging as well.

Mr Greg Fougère: My name is Greg Fougère and I'm the chair of the institutional long-term care committee of the Council on Aging, which is the standing committee of the council. The council, as Sylvia will introduce, involves representation from seniors, interested citizens and providers. This institutional long-term care committee is representative in that way.

As a provider, a professional working in the field of long-term care, I've worked for the last 15 years in the community home support area, in the homes for the aged

area and I'm currently in a chronic care hospital. I'm here as support to Sylvia, who will be presenting today.

Mrs Goldblatt: It just occurred to me that there is one other thing I'd like to say before starting on this brief. In a former life, I worked for Canada Mortgage and Housing in the area of social housing, which involved housing for the disabled and the elderly, and have been in this gerontology field for about 30 years. I always jokingly said I was involved because of enlightened self-interest. Of course, I never realized the validity of that until I hit 70. I can tell you that yes, this is a great field to be active in when you're younger so that it's there for you when you are older.

Mr.Jackson: That's enlightening, yes.

Mrs Goldblatt: That's a message to all those people who don't have grey hair.

Mrs Caplan: For as long it takes for this policy to be developed, we'll all be there.

Mrs Goldblatt: You'll have arrived.

The Chair: Order, please.

Mrs Goldblatt: You can see what I started.

Let me tell you a little bit about the Council on Aging. It's a voluntary planning, coordinating and advocacy organization. It serves 70,000 residents in the Ottawa-Carleton area who are 65 years of age and over. The council is composed, as Greg said, of seniors, professionals working in the field, care givers and other interested persons and has been operating since April 1975. You can see we're aging too. Members study issues of interest and take advocacy stands when appropriate.

The council has been very supportive of government initiatives which will enable seniors to remain in the community for longer periods of time, and yet it acknowledges the importance of the availability of quality care in institutional settings when it's needed. The principles of choice, self-determination and independence—and I heard these referred to several times this afternoon—are central to the council's philosophy. You'll recognize this commitment in our response to Bill 101.

In order to prepare our response to Bill 101, the council established a task force with representation from various council committees, as well as from the board of the council. As the vice-president of the Council on Aging, my comments will focus on the implications of Bill 101 from the perspective of a consumer.

Our brief will deal specifically with four issues that relate to the following areas of change to the legislation: funding reform; access to facilities; accountability and quality assurance; and direct funding service model. When we get to that one, I know you have used it as an area that is concerned primarily with the disabled, but we have developed a thought on that score that we we'll discuss a little later.

The first item I'm dealing with is the funding. The council supports a uniform method of funding for charitable and municipal homes for the aged and nursing homes in recognition of the reality that many residents in these facilities actually require the same level of care. We also recognize that former discrepancies in funding formulas for these facilities have resulted in a hardship for many

for-profit operators to allow them to provide the level of care that residents require.

However, it is imperative that equalization not result in decreased levels of service in the non-profit sector. That's an important point. For example, the non-profit areas provide social work, patient advocacy and sensitive administration of means testing. These are valued services available in many homes for the aged and necessary in the for-profit sector, but often we're not in a position to provide them.

1550

Bill 101 should be an instrument to establish an appropriate level of funding which reflects the real costs incurred in providing an appropriate range of services which are sensitive to the health, social, psychological and spiritual needs of the residents. A reduction in the present level of services in charitable and municipal homes for the aged would be unacceptable. That little warning, I think, stems from the fact that we realize that where the dollars are going to be placed is always a matter of judgement.

We're simply making the point that it's terribly important that we not lower the standards of service for the elderly across the board in an attempt to provide a greater degree of efficiency or a greater degree of equalization. We recommend that equalization of funding reflect the real costs of providing an appropriate range of services for residents in for-profit homes and that services in the non-profit sector be protected so that we don't go to the lowest common denominator.

The council has concerns regarding the ability of facilities to adapt to the changing care needs of residents following the implementation of a funding process that is based on an annual level-of-care classification. Since the long-term care reform will result in many seniors being able to remain in the community for longer periods of time, in many instances when seniors are admitted to long-term care facilities they are sure to require more care and are apt to decline more rapidly than in the past.

Under the proposed system, residents are to be classified annually in order to determine the funding for the facility. It is unclear whether the facility will be able to provide appropriate care for residents if their care needs increase significantly during the year without a comparable increase in funds. The council recommends that a process be included within Bill 101 to ensure that facilities will be able to provide appropriate care between annual assessments.

Our next point refers to collaboration in the placement process. The fundamental issue, when examining access to facilities, is how to enable the province to coordinate access to, and manage the use of, scarce facility services to ensure that those most in need gain access.

Ottawa-Carleton is very fortunate to have a well-established placement coordination service which has provided quality service to the seniors in our region since 1976. It has been through the collaboration between institutions, applicants and the placement coordination service that the needs of seniors requiring placement have in fact been met. Consumer choice remains central to the concepts of self-determination and independence and is key in the

placement process. It is important that this history of cooperation continue in the region. However, it is recognized that there may be occasions where agreement in the placement decision cannot be reached.

The council has several concerns regarding the appeal process under these circumstances. Placement is often an emotional time for seniors and their families. The appeal process is the mechanism by which consumers are assured that in the event that agreement cannot be reached between parties, there is a process outlined in the legislation which gives the consumer an opportunity to appeal the decision.

We refer to subsections 9.8(3), 19.2(3) and 20.4(3) of Bill 101 which state, "One member of the appeal board constitutes a quorum and is sufficient for the exercise of the jurisdiction and powers of the appeal board under the act."

The council believes that consumers' rights may not be respected if the possibility exists, as laid down in the legislation, that one person could conceivably be charged with resolving the placement decision. Our recommendation is that not less than three persons constitute a quorum in order to facilitate an unbiased decision on the part of the appeal board.

We discussed the composition and operation of this appeal board. Under the sections noted, Bill 101 states that, "Not more than one member of the appeal board members holding a hearing under this act shall be a physician."

Now, we're recommending that it be mandatory that a physician sit on the appeal board, since one of the most significant factors taken into consideration regarding placement is the medical need of the client, so the absence of a doctor on that board could be a real deficiency.

The manner in which the appeal board operates is key to its effectiveness. We're recommending that the appeal board hearings be held locally and that appeals be heard and a decision made within 30 working days. We're also dealing with people, like this committee, who are running out of time. With older people there is really very little time available. They can't sit around waiting for a process to provide them with an opportunity to get some kind of reasonable decision.

We're discussing the right of appeal for institutions. The appeal process should be available not only for clients but also for institutions which may not agree with the decisions made by the placement coordinator. The proposed admission process greatly diminishes the right of institutions to refuse clients. Without consideration of an institution's reasons for not wanting to admit certain clients, the care provided to other residents could be jeopardized. The admission criteria should enable a right of refusal by institutions in cases where justifiable reasons exist. Our recommendation is that there be equal access to appeal for institutions as well as for consumers.

Our next point has to do with cultural sensitivity in placement, and I notice since I've been sitting here for a couple of hours that this one's been addressed before. It is important in our community. We have a very large francophone community, and we're very aware of how often that francophone community is underserved. So we're making the point that it's important that francophone seniors have equitable access to long-term care facilities and that

placement coordinators continue to be sensitive to their cultural and linguistic needs.

In addition, there are ethnic and religious groups such as Jewish, Italian, Japanese, Chinese, Catholics, East Indian and aboriginal peoples—I've probably left out a few—for whom it is vitally important that their religious, cultural and linguistic requirements are respected. When people reach an advanced age, they often feel more comfortable using their mother tongue and sharing their life with those who share their culture.

1600

Our final comment deals with the placement advisory committee regarding the issue of access to facilities, concerns that are known as hard-to-place clients. Here we're referring to people with Alzheimer's, mental confusion or this kind of thing—is this one making you happy?

Interjection: No, Elinor says Randy—

Mrs Caplan: He's hard to place.

Mrs Goldblatt: Oh, you think he's hard to place. Well, maybe he hasn't quite reached that point yet. These persons often have difficult behaviours—does he have difficult behaviours?

Mr Jackson: Yes.

Mrs Goldblatt: Yes—and pose a significant challenge to the placement coordinator when attempting to find an appropriate facility which could meet their needs, while at the same time respecting the rights and needs of other residents.

Interiection.

Mrs Goldblatt: Yes. I can well appreciate that by this time you're all feeling a little bit slap-happy, because you've been here so long. However, I will finish shortly.

It's recommended that a local multidisciplinary committee be established which could be called upon to provide advice and direction to placement coordinators faced with difficult placement decisions. That's a really tough decision call and we feel it really requires a multidisciplinary committee to help the placement coordinators to make decisions that are good for everyone.

It's further recommended that cases should be heard and disposed of in not more than 30 working days in order for the placement advisory committee to be effective. One of the potential benefits of this proactive approach could be a reduction in the number of cases brought before the appeal board.

Here we're talking about planning for changes in legislation. The public has been given the opportunity to comment on Bill 101 without knowledge of the regulations referred to in the bill and to which facilities must comply. In effect, our comments today are based on only part of the legislative package. It's important that the regulations are made available to all interested parties in order that they can understand and comment on what appears to be acceptable or unacceptable. With confidence in the process, I'm very hopeful that the fact that you are giving us this opportunity to talk with you before issuing the regulations is going to make it possible for you to incorporate some of

these ideas in the regulations and we look forward to seeing them there

The inspection process and the role of accreditation: It's recognized that the inspection of facilities serves as an important role in ensuring that regulations are followed for the safety and security of residents. We realize, however, that compliance with regulations is not synonymous with quality of care. Furthermore, extending the inspection process beyond nursing homes to homes for the aged will incur a considerable expense.

Despite the important role inspection plays, the voluntary process of accreditation provides a valuable way to educate and assist facilities in improving the quality of service to residents. Due to the expense of increasing the scope of the inspection process and the merits of accreditation, a process should be stated in Bill 101 which would enable inspectors to focus their efforts on facilities for which the inspection process may be more necessary.

Our recommendation is that inspection should be on a less regular basis for those facilities which have a good accreditation rating and no complaints lodged against them. It's also recommended that the inspection process be of first priority for facilities without accreditation or for which complaints have been lodged.

An outstanding issue which relates to the inspection process is the government's responsibility to act when a facility has been found to be substandard. This is one very close to our hearts. In the past, facilities have been placed under the enforcement branch of the Ministry of Health. However, placements may continue to be made to those facilities. It is unclear under the proposed legislation how such homes will be dealt with.

One of the major challenges of the funding reform will be to ensure that private entrepreneurs meet the regulations without the threat of withdrawing funding. This is a critical issue for the government to address due to the number of nursing homes which are going bankrupt across the province at the present time. The government must come to terms with its position on the place of the for-profit sector in the delivery of long-term care services in institutional settings.

In light of the legislation under review, clarification is needed regarding the term "extraordinary event." When compliance to regulations relates to expenditures for renovations to a building, for example, and compliance is not financially feasible, provision should be made for capital financing for the private sector under certain circumstances: for example, when the facility is providing quality care to residents and the building is worth additional investment. We just don't want the people living in those facilities to suffer and this is one way that issue can be dealt with.

Our recommendation is that structural upgrading of facilities be included in the concept of extraordinary events. It's understood that upon inspection some facilities may need to be closed. In the past, when inspection has shown a facility to be unacceptable, there has been a lack of government action. This set of conditions must not be permitted to continue. We've all heard some of those horror stories and we'd like to see this as the occasion on which that ceased to exist.

This lovely word "exculpatory" clauses in the legislation: A final point regarding accountability relates to certain clauses in the legislation which appear to give unconditional immunity to certain professionals in the execution of their duties, and I heard that referred to by other briefs as well. Section 9.6 and subsection 10.2(1) to be introduced in the Charitable Institutions Act and sections found elsewhere in Bill 101 state that no proceedings for damages shall be commenced against a placement coordinator or an inspector for any act done in good faith.

We think there is no acceptable reason why these persons should not be liable for their actions, as are other professionals who have responsibilities to the public. Our recommendation is that clear guidelines for admission to facilities be established in order to avoid abuse of the system by any of the interested parties.

New sections 9.12, 19.5 and 20.8 to be inserted into the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act, respectively. provide that the institution develop a plan of care to meet each resident's requirements. The resident is to have access to the plan of care, but input into the plan has not been stipulated in the legislation, so it's hard for us to see how they are going to have an opportunity for this kind of participation.

We're recommending that provision should be made for the resident, his or her family, attorney or guardian to have input into the plan of care, consistent with the rights of the individual enshrined in the Substitute Decisions Act and the Consent to Treatment Act. The Council on Aging made presentations with respect to those as well.

The fourth and last issue I'm addressing today is the direct funding service model. The council commends this initiative and welcomes the flexibility it will bring to persons with disabilities in the purchasing of services to meet their individual needs. We realize that you're referring really to younger disabled people, like quadriplegics and this sort of thing. I have seen, in Toronto and Ottawa, examples of where this has successfully been achieved and you're able to accommodate quadriplegics in an apartment building in downtown Toronto and have attendant care workers who are hired by the users of those attendant care workers and they can remain in the mainstream of society.

We're saying it's a reality that as people attain a more advanced age, 80 and over—a little aside: Somebody said old is always 15 years older than you are so, at 70, I'm referring to people 85-plus—it's a reality that as they grow older the chances are higher that they will experience physical or mental disabilities that threaten to institutionalize them. This is particularly true for those who live alone. Although this section of Bill 101 may have had younger people with serious physical disabilities in mind, there is the potential here to use this concept to address the issue of supportive housing for frail elderly people. It would enable them to live independently with the security of having available the support services they require.

For the many years I worked in housing, it was always a source of great frustration that it was so difficult to get the ministries of Housing, Health and Community and Social Services to sit down together around the same table and solve the problems of the same people each of them was dealing with, but it was so difficult to get that kind of process moving. I would say we are a little closer today. I think we should feel a little bit of encouragement on that score

Our recommendation is that the government consider broadening the scope of the direct funding service model to include supportive housing for the frail elderly.

In summary, the Council on Aging supports the move towards equitable funding between homes for the aged and nursing homes, but it cautions that revisions to the funding scheme not be punitive to the non-profit sector. I think I explained what we meant by that. We realize that the forprofit people have not been able, in many instances, to provide what the not-for-profit people have done and we don't want everything brought down to the lowest common denominator. It is also recommended that mechanisms be established to enable funding to be sensitive to changes in levels of care between annual assessments.

The council supports the continuing role of the placement coordinator but it suggests that revisions be made in the appeal process. It is recommended that the quorum for the appeal board consist of three persons, one member on the board should be a physician and that the hearings for the appeal board should be local and timely. It is further recommended that a multidisciplinary committee be established to assist and direct placement coordinators regarding hard-to-place clients. It is also recommended that the appeal process be broadened to include the possibility for institutions to appeal placement decisions as well as residents.

The Council on Aging recognizes the valuable role inspection plays in ensuring that facilities comply with regulations. However, the council would like to see an increased emphasis on the accreditation process. The government should be responsible, through the inspection process, to ensure that facilities which are clearly substandard are dealt with in an expedient manner to ensure the wellbeing and safety of residents. It is recommended that options be included to assist with capital renovations if the facility is a viable operation and it is clearly apparent that compliance is impossible. Furthermore, in order for the system to work in the best interests of seniors, professionals involved in the placement and inspection activities must be held accountable for their actions.

Finally, the Council on Aging strongly supports the initiative towards direct service delivery funding and recommends that this process be broadened to encompass supportive housing initiatives for seniors.

On behalf of the Council on Aging of Ottawa-Carleton, I would like to thank you and the members of the standing committee for your attention after all these hours of sitting here, and request that my comments made here today be considered in the revisions made to Bill 101 in light of their value from the standpoint of the consumer.

The Chair: Thank you very much for a very thorough presentation. It is much appreciated. Again, the Chair hates to play the heavy, but if I could just ask for one question from each caucus and just one, please, as I'm afraid we are tight.

Mrs Goldblatt: Also, I'm likely to be long-winded in my answers too.

The Chair: That's why the members, I know, will be brief with their questions and we'll begin with Ms O'Neill.

Mrs O'Neill: As usual, the Council on Aging has done its homework and the task force can be congratulated. I'd like to compliment you on a couple of things: your challenge and your hopefulness that we will have listened to you in the formation of the regulations. We in the opposition won't have much to do with that, but hopefully your message will be carried forward.

I also want to say that the appropriateness of care between annual assessments is another very important issue brought forward, and the quorum of the appeal board I think also needs to be highlighted. I think the clarification regarding capital investment is also something we have to attend to.

I have but one question, as Mr Chairman stated. I would like you, if you could, to expand on what you have a feeling for or what you said about the multidisciplinary committee regarding the placement, what your vision of that is.

Mrs Goldblatt: When we say "multidisciplinary," who are the service providers we are talking about in providing support services for seniors? You have the medical people, the nurses, the doctors, you have the social workers. Always, from a consumer perspective, I would say to have a consumer there as well is an important factor, so when we say "multidisciplinary" we're simply referring to the professions that currently serve the support services for seniors.

Mrs O'Neill: I hope that idea will be given serious consideration.

Mr Jackson: I appreciate the clarity with which you have referenced the sections and the requirement for amendment. That is helpful to us. I was hoping I could further clarify your point, because it will be used in your absence.

Mrs Goldblatt: What point is that?

Mr Jackson: The point about how fortunate it is that the regulations are not before us. You are perhaps the first and only and the last person to suggest that, so I'm going to pursue that with you. I don't wish to go to Kingston tomorrow and have someone say the Ottawa Council on Aging was very pleased that we don't have regulations.

Mrs Goldblatt: Well, you notice that wasn't stated in the brief.

Mr Jackson: Can I put it in the form of a question? I won't get a second run at this?

Mrs Goldblatt: All right.

Mr Jackson: It is quite common for the regulations to be tabled at the same time as a sign of faith. They can always be amended.

Mrs Goldblatt: That's true.

Mr Jackson: Many of the concerns raised would unnecessarily have to be raised if the government had already

felt they belonged in regulations, so I wish to ask you to clarify further: Do you believe that, had we had the regulations, it would be more helpful to the process of understanding and therefore supporting long-term care?

Mrs Goldblatt: Yes, I would say it probably would have been.

Mr Jackson: The draft regulations. **Mrs Goldblatt:** Right, a draft.

Mr Jackson: Because this is draft legislation.

Mrs Goldblatt: It's draft legislation. You make a good point.

Mr Jackson: It is regular legislation, but it would be draft regulations that could be approved at a future time but you'd give input. So you feel that would be better than not having them at all?

Mrs Goldblatt: Yes. I think your point is well taken.

Mr Jackson: Thank you very much

The Chair: A final short, sharp question. Mr White.

Mr White: Thank you very much for your presentation. The Council on Aging has reason to be proud of your presentation and of you. I also want to thank you for your generosity. Here you are in the midst of your presentation and there is a minor disruption with our young scalliwag, Mr Hope, and rather than feeling as if people weren't paying attention to you, you said, "Gee, I guess you people have been sitting for a long time." I really appreciate that.

Mrs Goldblatt: I'm happy to hear that. You've got to recognize that at 70, I've had lots of life experience, which has included everything.

Mr Jackson: Scalliwags and patience.

Mrs Goldblatt: Patience, especially.

Mr White: Anyway, the point that Mrs O'Neill brought up in regard to the placement advisory committee, this is actually something which hasn't been articulated in this kind of way before and I found it quite interesting, and there were a number of issues around the appeal process and you talked about cultural sensitivity, the hard-to-place clients.

Mrs Goldblatt: Right.

Mr White: It reminds me of a hard-to-serve or troubled youth.

Mrs Goldblatt: I don't have to tell you how the Alzheimer disease has become something to which we're all so sensitive. For some families the point is reached where they simply cannot carry the burden any longer.

Mr White: I was just wondering: With the importance of, I would suggest, the appeal process and this point you make in regard to the placement advisory committee of what is primarily a psychosocial issue, whether it might not in fact be appropriate for a social worker to be on this placement advisory committee.

Mrs Goldblatt: Absolutely.

Mr White: Someone who can deal with families and with a troubled situation.

Mrs Goldblatt: I'm so glad you said that, since social work is my background. You guessed that, didn't you?

The Chair: On that note, may we thank you again for coming before the committee and for providing us with your presentation. Thank you.

Mrs Goldblatt: Our pleasure. Thank you.

CANADIAN COUNCIL ON HEALTH FACILITIES ACCREDITATION

The Chair: I now call upon the Canadian Council on Health Facilities Accreditation. Welcome to the committee. If members are searching, the brief from the council was circulated last evening. There will be a skill-testing series of questions as we leave the room. Thank you very much for coming; if you would please just introduce yourself and then please go ahead with your presentation.

Mrs Elma G. Heidemann: My name is Elma Heidemann. I'm assistant executive director in charge of standards, research and development at the accreditation council. I would like to say thank you very much on behalf of our organization for making available this opportunity for us to present to you.

It occurred to us, when we planned this presentation, that the first thing we should do is to tell you who we are and what we do. We are not an organization, I think, that is well known to most individuals. Perhaps I can start by saying we are a national accrediting body for health care organizations. Our mission is to promote excellence in the provision of quality health care and the efficient use of resources in health organizations throughout Canada.

The council provides organizations within our program with the opportunity for voluntary participation in an accreditation program which is based on national standards, self-evaluation and professional input from the whole health care system. The council was incorporated in 1958 to set standards for Canadian health care organizations and to assess their compliance with these standards. We are a non-profit organization as well as a registered charity.

The council has recruited and trained 268 surveyors who make the onsite visits to carry out accreditation surveys. These surveyors are all practising senior health care professionals who serve the council on an honorarium basis. I can assure you none of them work for the honorarium either, it's so small.

The total number of facilities accredited by CCHFA—that is how we are known in the health care world—as of December 31, 1992, is 1,306, including 583 long-term care centres, 643 acute general hospitals, 52 mental health centres and 28 rehabilitation centres. It should be noted that the long-term care centres include nursing homes, homes for the aged and chronic care facilities. In addition, new accreditation programs are being developed for cancer treatment centres, community health centres, northern nursing stations and northern health centres and home care.

There are three different levels of award that are granted by the council's board of directors to recognize health care organizations' compliance with the council's standards: a four-year award, which is our award of excellence, three years and two years. If circumstances warrant, the council may also require a follow-up report from the organization or a revisit as conditions of the award.

In consultation with health care organizations and professionals, CCHFA has identified the following key parameters for the evaluation of an organization. If you'll permit me, I will go through them, because I think it's important for you to know the scope of what we look at.

We look first at resident care. The focus of our standards document is in fact around resident care. We then look at the quality of this care or other services that are provided by the organization; we look at safety; we look at the mission of the organization as it is related to the needs of the community and how those needs are carried out through the organization's activities; we look at the strategic plan of the organization to ensure that the services and activities of the organization are unfolding in a timely and organized manner; we look at communication within the organization, with residents as well as with the community; we also look at how the organization itself is organized and whether it is organized appropriately to be able to carry out the work that it does; we also look at policies and procedures; how resources are used; and how the education of staff and residents and the community, as a matter of fact, is carried out.

1630

We have four areas we would like to comment on regarding Bill 101, if you'll permit me. The first of these is the requirement for a plan of care and a quality assurance plan.

The amendments to the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act—and I think in the document itself we give the specific references to the clauses—require that a plan of care for each resident be developed and revised as necessary and that a quality assurance plan for the organization be developed and implemented. Both the resident-specific plan of care and the organization-wide quality assurance plan are absolutely necessary if quality service and care appropriate to each individual resident are to be provided. CCHFA commends the amendments for their emphasis on these vitally important components of long-term care.

While commending the amendments, CCHFA would be remiss if we did not point out that those long-term care facilities which currently participate in the CCHFA accreditation program will already have voluntarily implemented, or will be in the process of implementing, both plans of care and organization-wide quality assurance plans. CCHFA standards not only cover the requirement for a plan for care, but also describe what the plan should entail and how it should be completed and used. The plan is to be based on resident need, involve appropriate multidisciplinary providers and be regularly reassessed. The plan of care is to include goals, actions and expected outcomes for the resident.

CCHFA standards also require facility-wide quality assurance activities to monitor and evaluate the quality of resident care and service, to identify and resolve problems, to improve processes, and to take action and follow-up to ensure continuous improvement in resident care and service. In addition, CCHFA standards also require the organization to have in place a process to manage risks to residents, staff and visitors in order to ensure an optimum

quality of life and to ensure the safest possible home for the residents and the safest possible workplace for staff. We have taken the liberty of providing each of you with a copy of our standards in case you wish to refer specifically to what we say.

The second thing we would like to comment on is the use of certain terminology, and particularly the term "quality assurance."

Over the last few years there has been a considerable move beyond quality assurance as the major vehicle for quality monitoring in health care to a concept known as quality management. This concept embodies several key concepts:

- 1. The resident or client is the focus of care or service and as such is the primary focus for quality monitoring.
- 2. Quality is the responsibility of everyone in the organization and thus everyone must be involved in quality monitoring.
- 3. Quality care is delivered by teams of providers and thus the monitoring of quality is also best achieved through team efforts.
- 4. The leadership of the organization must be supportive of organization-wide quality monitoring and facilitate its implementation.
- 5. Efforts must be made to continuously improve quality, especially of the processes involved in the delivery of care or service, and to determine outcomes of care.

CCHFA will begin to use the term "quality management" and the key concepts just described in all its 1994 standards documents. It should also be noted that the Ontario government, especially the Ministry of Health itself, has begun to use this terminology and has especially emphasized the concept of continuous quality improvement, so we think that its use is in keeping with the government's philosophy.

The next point I would like to comment on is the process for monitoring quality as specified—or not specified—in the legislation.

It is unclear in Bill 101 what the government's specific role or roles in monitoring quality will be as a result of this legislation. It will be clearly acknowledged by all that the government, representing the people of Ontario as the funders of care, has a major role to play in ensuring that quality care is delivered. In carrying out this role, however, the government has two major options.

The first of these is to control the total process of quality monitoring, which involves setting the parameters of care for what constitutes quality care, establishing the standards for the delivery of that care, monitoring on an ongoing basis whether standards are being met and, finally, solving any problems which arise from this ongoing monitoring.

The second option is for the government to control only part of the process, particularly its beginning—that is, the setting of parameters of care—and its end, solving problems which are highlighted by the quality monitoring process.

The first option clearly provides the government with the most control, but it also obligates the government to provide internal infrastructures to carry out all the steps in the process and, of even more importance, to correct any problems which emerge. It also places the government in a constant potential conflict-of-interest position if it seeks not only to establish the parameters and standards, but then to monitor compliance with those standards and correct any deficiencies which emerge. It would not be hard to imagine, for example, that if funding grew short, lowering of standards or glossing over of problems which arise as a result might occur.

It appears to be preferable for the government to pursue the option of retaining control of the beginning and end of the process. This would eliminate the need for costly internal government infrastructures for standard-setting and ongoing monitoring, yet would provide both the opportunity for the government to define the parameters of quality care within the province and the information which might trigger inspections, clearly the domain of the government, when problems are uncovered. This second option would provide the government with effective control without potential conflict of interest and without a commitment to additional expensive internal infrastructures.

It should be noted that the CCHFA accreditation program now provides a process wherein standards are created through wide national field consultation and quality is monitored on an ongoing basis through a combination of self-assessment—and we can't stress enough the importance of self-assessment—and peer review. This process is, for currently accredited long-term care facilities in the province, already providing standard-setting and ongoing assessment.

It should also be noted that CCHFA recently had the opportunity to review a draft of the Long Term Care Facility Programs and Services Manual prepared by the long-term care division, Ministry of Health and Ministry of Community and Social Services, dated October 1992. While we were extremely pleased to see so many of the standards from the CCHFA long-term care standards document appearing in this document, we could not help but wonder at the seeming duplication of effort which the ministry document represents.

The next point we would like to talk about is the precise nature of quality assurance for Ontario long-term care facilities which are part of the CCHFA accreditation program.

The CCHFA, through its accreditation program, currently provides external, objective, national quality monitoring to 294 long-term care facilities in the province of Ontario; that is, 240 nursing homes and 54 homes for the aged—this excludes chronic care, by the way—which is approximately 54% of the total number in the province. This figure accounts for 35,567 beds and an annual budgetary expenditure of well over \$1 billion. The average yearly cost for a facility to participate in the CCHFA accreditation program is \$1,900.

We have provided you in your document a table which elaborates how these figures are arrived at. The yearly cost for accreditation is approximately 0.05% of the total operating budget of participating long-term care facilities—an excellent return, we believe, for the investment made to monitor quality. It should also be noted that the government has recognized the value of accreditation in the past

by offering an incentive of 33 cents per accredited bed per day for nursing homes to participate in the accreditation program. This small incentive—which, by the way, covers the cost of accreditation—has resulted in the high participation rate, 73%, of nursing homes in the province in the accreditation program.

These figures demonstrate the considerable extent to which Ontario's long-term care facilities are already involved in effective, efficient and ongoing quality monitoring through their voluntary participation in the CCHFA accreditation program. It should also be noted that the CCHFA accreditation process also provides for consultation and education from experienced peers in their capacity as surveyors. It is hoped that if Bill 101 is passed, there will be continued support for the ongoing participation of these organizations in the voluntary quality monitoring program which they have helped to create and for which there appears to be widespread and continuous support.

1640

Perhaps I can just summarize. Bill 101, if passed, will have significant impact on the organization and delivery of long-term care in the province of Ontario. We have welcomed the opportunity to comment on this legislation. We ask specifically that the four following points be considered:

First, we commend the legislation for its emphasis on the need for a plan of care individualized for each resident and for the requirement for each organization to have a quality assurance plan. We also note that both are already requirements for facilities accredited by CCHFA.

Second, we suggest that the term "quality assurance" be replaced by "quality management" and the concepts embodied in it. We note that we will begin to use this term ourselves, the term "quality management" and its concomitant concepts, within our revised 1994 standards. I might add that considerable national consultation has been done to assess the appropriateness of this change in terminology.

Third, we wish to express our concern regarding the lack of clarity in the government's role in the quality monitoring process. We suggest that the government retain for itself the establishment of parameters of care and the inspection function when problems are discovered, but that the establishment of standards and the ongoing assessment of compliance with those standards to ensure that the parameters of care are being met in care delivery be left to long-term care organizations in conjunction with an external, objective monitoring agency such as CCHFA. What would thus be created is a collaborative quality monitoring process which is both effective and efficient. We would welcome such collaboration.

Finally, we suggest that the current extensive participation by long-term care facilities in the province in the national accreditation program be recognized and supported as an effective and efficient way of meeting the requirements of Bill 101. We further suggest that those facilities not currently accredited be encouraged to enter the accreditation program.

Mr Chairman, thank you very much for allowing me to appear on behalf of my organization today.

The Chair: Thank you very much for coming, both for your brief and also for providing the members with a copy of the form or manual which you use. I would like to move directly to questions. Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. First, with respect to the language, do you feel that "quality management" would be broad enough to encompass everything you'd like? I know you have requested that we replace the words "quality assurance" plan.

Mrs Heidemann: Yes, I feel it would be broad enough if it embodied the concepts that we mention in the brief, particularly the concept of quality improvement, the concept of total involvement of the organization in quality monitoring and the belief that leadership of organizations has to take the responsibility to promote quality monitoring.

Mr Wessenger: When you do an accreditation process, how often do you do that for each institution?

Mrs Heidemann: The length of time depends on what we find in the organization. If, for example, we find quite good compliance with the standards, then the three-year award would be given. We may find one area or something where we have particular concerns. If that is the case, then we could either request that the facility give us a report on that area or send someone in after three months or six months—again, depending on the nature of the problem—to see that the problem has been corrected. If we find more problems, then a two-year award would be given, again with a report or a revisit. If we find significant problems, then we remove the accreditation status.

Mr Wessenger: Do you measure any outcomes with respect to your process at all?

Mrs Heidemann: In terms of our own evaluation of our process? Yes. We believe that the best evaluation of the process is from those who participate in the process itself, so we have quite an extensive evaluation that follows a survey, where the facility evaluates not only the process but also the surveyors and the use of the standards. In addition, all our surveyors are evaluated yearly and are given feedback from all the surveys they participate in. In addition, we do periodic reviews with all facilities in our program. This is generally done through a survey. For some reason, we generally get about 98% response when we survey the field.

Mr Wessenger: Do you also look at consumer satisfaction?

Mrs Heidemann: Yes, we do. These are our consumers. We are just now beginning—and we're building it into all our surveys in the next few years; we have done it in long-term care for some time—actually speaking to residents as part of the survey. We also now are looking to other national and provincial organizations to give us feedback as well on the process.

Mr Wessenger: What happens with respect to problems in one of your accredited facilities; for instance, a large number of complaints, other types of problems? Do you have any process where you can take back the accreditation. **Mrs Heidemann:** Sorry, I don't understand. If we get a complaint from, say, a resident or a family member?

Mr Wessenger: Yes. If major problems come up with respect to the way the facility is operated, do you have any process where you can remove the accreditation?

Mrs Heidemann: We have a process whereby we can go back into the facility to discuss the problem. Removing the accreditation has to be done by our board and would really depend on the nature of the problem. Our first preference would be to work on the problem. It's very hard without a specific instance to say what—

Mr Wessenger: The reason I asked this is that evidently there have been instances of major problems with respect to certain accredited facilities.

Mrs Heidemann: Perhaps you could describe the nature of the problem and then I might be able to tell you more what we would do

Mr Wessenger: Perhaps I won't, but I think there was one case where an accredited facility actually had to be closed

Mrs Heidemann: I think there were some problems some time ago about use of funds within the facility. You will appreciate that because funding is a provincial matter, we do not do a thorough audit. It is felt that this is the domain of the province and would be seen to be overstepping our boundaries. If there is a misuse of funds or something, we would not look at that.

Mr Wessenger: Would you see your role, then, as a complementary one along with a monitoring system, that you'd need both a monitoring system and an accreditation system?

Mrs Heidemann: It depends on what you are monitoring. If you are monitoring quality of care, it's a duplication. If you are monitoring the precise use of funds, it's complementary.

Mr Wessenger: Fine, thank you.

Mrs Caplan: I have a series of short questions.

The Chair: I love a series of short questions. **Mrs Caplan:** It's good to see you again, Elma.

Mrs Heidemann: It's nice to see you too.

1650

Mrs Caplan: I don't know if you've been following Hansard, but we've had quite a lot of discussion about an alternative to the punitive enforcement model this bill contains. That really, I think, was the essence of the parliamentary assistant's questions, so I'd like to elicit some responses on what an alternative model could look like, if you had a model or amendments to this legislation that required accreditation both for outcome and management; that required a quality management program as a part of the legislation; that required a client satisfaction survey clearly, so that you had that; that required the kind of residents' council participation so that it wasn't just a question of checking off but in fact you were able to look at what the results or the outcome of the participation of that council would be; perhaps where you even would require financial disclosures as a complementary component to that. In the case where you have complaints, which is what the parliamentary assistant referred to, you're very aware of the steps that the ministry can take under the Public Hospitals Act?

Mrs Heidemann: Absolutely.

Mrs Caplan: If you had that kind of process as a safeguard, do you think that kind of model would give the kind of public accountability and confidence so that the ministry wouldn't have to have what you referred to as option 1, which is a duplication of the kind of process that accreditation and all of these other safeguards could provide?

Mrs Heidemann: Perhaps I can comment on that from a number of different aspects. First of all, our belief is that certainly much has been accomplished through a voluntary quality monitoring system. It may not be perfect, but we have made great strides. We believe that part of the reason we have made great strides is that there is voluntary participation. No one is holding a club over the head of the facilities. If it is the wish of the government of Ontario to enshrine accreditation in the legislation, then so be it, but we would stress to you that so far it has been a voluntary process and has, we think, worked reasonably well.

Mrs Caplan: Would it be possible, from your view, to build in an incentive for that? For example, if a long-term care facility received an accreditation or participated voluntarily in the accreditation program and had an annual client satisfaction survey, had a quality management program acceptable to the ministry, had an active residents' council and perhaps even a community volunteer board—I mean, you could have a number of things—it would then be exempt from certain sections of this bill as it related to the inspection model. Do you think that would work?

Mrs Heidemann: You would have to be the judge of that. I think we can describe our process. If you and the government feel that this is sufficient to accomplish what is the intent of the bill, then I think it would suffice. My own belief is that there is a great deal of value from the accreditation process which could be, and is currently, complementary to what the government needs to do.

Perhaps I could just talk a moment about resident satisfaction, since it's been brought up a couple of times. We are currently looking at this and we're not very enamoured with the kind of tools we are finding for assessing resident satisfaction, principally because they don't seem to get at the quality-of-life issues sufficiently well. That is a deficit at the moment. It's a deficit in long-term care, it's a deficit in acute care, it's a deficit everywhere. We just don't have the tools.

But we're beginning to explore something perhaps called "resident status", where you can actually measure the status of a resident, not only on physical parameters, but on psychological and quality-of-life parameters. You can do this measurement periodically to see if there is a change that is either acceptable or not acceptable. We think that may be a more interesting and better return for what's invested, a better vehicle for us to explore.

But at the moment, I'll tell you right now, we do require resident satisfaction kinds of things. We do require, in the acute care setting, patient satisfaction, but we just

don't find that it yields that much that is helpful. This is for development in the future, and certainly it will be a major focus for us because it's something we want in the standards.

The Chair: Final.

Mrs Caplan: Final question: I'd like you to tell us a little bit more about the changes your organization has gone through as you have been developing and implementing the total quality management and continuous improvement outcome approach to accreditation, which is very different from what accreditation was even five or so years ago.

Mrs Heidemann: Yes, this is a process that has occurred in the last five years. I think prior to that we were very much an inspection process. Our surveyors considered themselves primarily inspectors and really behaved pretty much as inspectors. But it began to dawn on us that this was a government function, that governments were quite clearly set up to do this reasonably well and that perhaps this was not the chief role or the main role we should be playing, or the most helpful role.

I think what we have shifted to in the last five years is more of a—if I can call it that—positive approach, which is to see the standards as guidelines for how a quality facility would operate and then to encourage facilities to implement the standards, really on an ongoing basis, so that you simply don't think about accreditation three months before the surveyors are going to arrive on the scene. This is an ongoing thing that you live with, day in and day out. In fact, whether the surveyors come or not, or when they come, should be immaterial to the whole process.

In reality, of course, it is a bit traumatic when you have the surveyors on-site, but we hope that gradually over time facilities will see this as an opportunity in which they can not only, I guess, air the problems they have, but also show the good things they are doing and get feedback from an outside, objective observer about this and really use the surveyors as a kind of consultant to help them work through whatever it is they want to work through.

What we're looking for now in our facilities is progress over time, so if on one survey you have certain problems, then on the next survey we will hope for and look for progress being made, either to change that or to move in a different direction. So—

The Chair: Thank you.

Mrs Heidemann: Sorry, Mr Beer.

The Chair: Finish your thought; I'm sorry. **Mrs Heidemann:** No, it's okay; I'm finished.

The Chair: I've got to play the heavy again. I'm sorry because this is, as I think has been said, a very interesting area that has come up. We want to thank you very much again for coming before the committee this afternoon.

Mrs Heidemann: Thank you very much. I might add that if there is any further information or if anyone wishes to speak with us further, we would be more than pleased to oblige.

The Chair: Thank you very much.

Mrs Caplan: Could I ask one question for Mr Jackson?

The Chair: No.

The Chair: I will ask for the representatives from Gerontological Nursing Association. This will be the last presentation this afternoon. If I could just note for members, this evening we begin at 6:30. The Ottawa-Carleton Placement Coordination Service is coming at 8; that may not be clear on your schedules. There'll be four presentations after supper.

Just very briefly, before we begin, Mr Hope.

Mr Hope: I've got some requested information through legislative research. I notice this is copy-dated 1991. I wonder if there's an earlier copy date. That's why I've raised the question to legislative research, because I know it might have one of the old manuals that it could tap into.

GERONTOLOGICAL NURSING ASSOCIATION OF ONTARIO, OTTAWA CHAPTER

The Chair: Thank you very much for coming before the committee this afternoon. I don't think we've had representation from your association in another part of the province, so we're grateful that you were able to come and be with us this afternoon. If you'd be good enough to introduce yourselves for the committee and for Hansard, and then please go ahead.

Mrs Frances Doyle: Yes, sir. We would like to thank you very much for allowing us the opportunity. I'm Frances Doyle and I'd like to introduce my colleagues: Jean Lindsay-Brown and Gloria Laporte. We represent the Gerontological Nursing Association.

1700

The Chair: Can I just ask you, is this a provincial association and you are the Ottawa chapter?

Mrs Doyle: We're the Ottawa chapter. I was going to introduce ourselves a little bit in the brief. First of all, I'd like to apologize. I had trouble with our printer today, or we would have had copies of our brief for you. But we have the address now and we will send copies of our brief to you in Toronto.

We're going to tell you a little bit about ourselves and make some observations and some recommendations that we noticed throughout the review of Bill 101. We certainly would like to answer any questions you might have at the end of our presentation, but we also would like to say that as nurses we are always feeling that we are advocating for the residents, and certainly that's part of our role. So a lot of our observations will be made around the recommendations for the resident in resident care.

The Gerontological Nursing Association of Ontario, incorporated as a non-profit association in 1979, directs the primary focus on improving the quality of life for older persons. The primary goals, in cooperation with other health disciplines, are to advocate for high standards of nursing care and related health services for older individuals and promote professionalism in gerontological nursing practice through education, research and support to our members.

There are eleven chapters across the province of Ontario, with a total membership of approximately 1,400 nurses. The Ottawa chapter, which we represent, has approximately 190 members who work in acute and chronic

care hospitals, nursing homes, homes for the aged, retirements homes and in community health.

The Gerontological Nursing Association commends the government for encouraging and welcoming opinions and advice from consumers, service providers, planners and advocates. As nurses engaged in the governance of quality care practice and in the respect for the needs of all elderly in Ottawa, we read with interest the proposed changes in the legislation and wish to submit some observations and recommendations in regard to the Long Term Care Statute Law Amendment Act. Bill 101.

Gerontological nurses support and applaud a health care system for older persons that is comprehensive and offers a continuum of services that is equally accessible to every older person in the province. We will address our remarks mostly to the following areas of this act: the coordinated access to facility services, the enhanced accountability and the levels of care funding.

First, we wish to discuss the redirection strategy of the coordinated access-to-facility services. We applaud the efforts of enabling a single-point access for services. We are pleased that services will be provided in the community and that all efforts will be made to prevent admission to long-term care facilities. We would question, however, the process of placement coordination services, the only people who are involved in the placement of residents in long-term care facilities.

Currently, the workload does not allow adequate time to review and process applications to their satisfaction. By broadening their scope of responsibility and managing waiting lists, following the legislation to the letter according to Bill 101, we believe this could cause delays for some individuals and place in jeopardy those elderly persons the government has set out to serve.

Also, in regard to the placement of seniors, there are other issues we would like to address. It is of great concern that residents' choice will be disregarded with this act. We believe it is their right to choose a facility where they are going to spend their remaining years. The admission facility should meet their cultural, religious, physical and emotional needs. Not considering these would be, we feel, dehumanizing and would decrease the quality of life for our elderly.

Also, it should be noted this may create permanent separation of the resident from his family or spouse. Residents and their families consider of paramount importance the location of the long-term care facility in relationship to their current address. If the distance between the long-term care facility and the family is great, the resident will receive less support by regular visits. Gerontological nurses acknowledge the central role that families and friends play in the lives of older persons and their health care.

Another potential problem we see is that if a facility cannot meet the needs of a particular client because of workload or untrained staff, the amendments create the power for the director to order designated placement coordinators to suspend admission to a given facility if there has been a pattern of refusal. Being forced to accept inappropriate clients may jeopardize the quality of life for both the new resident and the other residents already in the facility.

We believe that placement services need to act in consultation with long-term care facilities. Our aim in long-term care facilities is to admit compatible residents in the same room to minimize the transfer of elderly residents, as this is so problematic to them. We would also like to indicate that inappropriate and aggressive behaviour is common in long-term care facilities, and here also we try to minimize the risks of injuries by again ensuring appropriate accommodation

So, as you can see, if there is not good dialogue between placement services and long-term care facilities, we could have potentially a great deal of problems that we create for our residents. Residents should not be placed in circumstances where a facility cannot safely or effectively meet his or her needs, and a facility should not be penalized for being honest or trying to accommodate special needs or circumstances.

We would like to recommend that placement coordination services be given the flexibility to use judgement and, in consultation and cooperation with the long-term care facilities, to facilitate better placement of our seniors. This brings us to the next area of concern, that of enhanced accountability.

The Standards of Gerontological Nursing, published in 1987 and revised in 1991, are specialty standards intended for registered nurses and registered nursing assistants working in the community or in institutional settings. Nurses follow standards designated also by the College of Nurses of Ontario, the Canadian Nurses Association as well as a code of ethics established by the Canadian Nurses Association. These standards require every nurse to assess our clients, develop and implement care plans for each and ensure that they are reviewed and kept current.

All gerontological nurses believe that this plan must reflect the physical, psychological, social, intellectual and spiritual needs. It is the basis of nursing practice. This legislation appears to question the professionalism of registered staff and can only serve as a demoralizing force. Nurses require working environments that support their rights and provide opportunities for them to fulfil their responsibilities. Gerontological nurses need to feel autonomous and would like to feel they are an empowered workforce with decision-making authority over day-to-day practice.

Long-term care facilities, by the very nature of the services provided, are accountable to both the public and the government. We understand and support the purpose of the legislation which is, of course, to protect consumers and enable their needs to be met in a very complex system. We recognize also the necessity of and respect the principles of the inspection process for all long-term care facilities. We also recognize that there is a duplication with the Canadian Council on Health Facilities Accreditation, which in fact you've just heard from.

Our concern arises with the statement in the statute, "The inspection scheme, similar to that which has governed nursing homes in the past." This is of concern to us. Currently, nursing homes are inspected by compliance advisers who ensure that there is compliance with the Nursing Homes Act, but that is not their only function. They act as a resource to the facilities. They offer assistance and

education in order to achieve quality of life for the residents. It has become a true consultative process.

1710

Returning to the past inspection process would, we believe, result in the negative policing connotation of the 1960s. This resulted in poor cooperation and left employees frustrated and angry. I also believe it left the inspectors frustrated and angry, and we spent a lot of money on a study that was done that showed this was so. I forgot which government of Ontario did the study now.

It is our recommendation that the process of compliance management currently being used in nursing homes would continue and thus encourage creative management and accountability. Current economic realities demand leadership and working together to ensure consistency in our practice will help to foster the quality of life that we are so concerned about for the residents in our institutions.

Now we would like to talk about the levels-of-care funding. We believe that more attention must be given to funding so that quality care and subsequent quality of life for the residents could be ensured with adequate staffing levels. Staffing ratios between professionals and non-professionals have really not, to this point, been studied or addressed. The classification system being used for establishing funding on an annual basis currently is insufficient to ensure the needed resources required for residents. Residents' needs cannot only be assessed from the point of view of activities of daily living, the behaviours of daily living and their continence care. Can you imagine being reduced to those three categories?

Gerontological nurses play a crucial role in the care of the elderly in long-term care facilities. They provide creative, humanistic and individualized care incorporating the concepts of prevention, rehabilitation and palliation. They facilitate a healthful environment and promote mutual goal-setting and decision-making among older persons to exercise their rights and responsibilities.

Gerontological nurses are also involved daily as managers, educators, consultants, researchers and counsellors. It is our recommendation that sufficient staff will be provided to allow for this so that the desired outcomes for the older person will be best achieved. This can only happen if the government recognizes the dignity and worth of older, frailer adults by implementing such positive action.

I would just like to summarize our recommendations. The first recommendation is that we believe placement coordination services have to be given the flexibility to use some judgement in cooperation and consultation with long-term care facilities that would facilitate better placement of our seniors.

The second recommendation is that if we have to have an inspection process the process of compliance management currently being used in nursing homes would continue. This does encourage some creative management and gives some accountability to the public.

The third one is that we really would like to have sufficient staff to provide for our elderly and to ensure that they have quality of life. We realize that not all individuals end up in institutions and we are very glad the government is looking at other ways of keeping residents out of long-term care. Unfortunately, there are and will continue to be residents who require facilities, so we are hoping that we be viewed as a facility which requires sufficient staff. I don't know how we ever arrived at staffing levels currently in existence, but we really need to have, I think, a good study done which proves how many professionals and how many health care workers are required to give adequate care.

We really thank you for listening to us and we would entertain any questions you might have.

The Chair: Thank you very much.

Mrs Dovle: I'll be all anxious for supper.

The Chair: Thank you none the less. If I can use the old saw, you have given us food for thought.

Mr Hope: Low calorie, too.

The Chair: Yes, low calorie too, that's right. We'll get right to questions.

Mrs O'Neill: I'm very pleased you've come. I've just been through a very personal experience of the loss of my father about six weeks ago. He spent his final days in what was termed, in an Ontario hospital, as critical care geriatrics and I've never seen nursing as I saw it. It included also the family and I'm sure that's part of your training. I want to compliment you because I'm sure those nurses were of your association.

I am very pleased that you highlighted, as not too many of our presenters have, the spousal component and the familial component of aging and the support system that's necessary, and sometimes the flexibility that isn't there, for spousal cohabitation. I'm happy you highlighted the weaknesses as you see them in Bill 101 regarding placement and also the negative connotations of the new policing—your term—and its sanctions. I think the sanctions component is very worrisome to some individuals.

I'd like you to say a little bit more because I have felt from the very beginning, from the first briefing and the day I saw Bill 101, that it does, in its tone at least, question professionals. We had some people say that to us today. You've said it the strongest, I think. Would you like to say a little bit more about how you feel Bill 101 questions or at least tests your professional qualities within its own contents?

Mrs Doyle: I think as a professional association, you believe in the philosophies and are certainly brought up to care for the residents, patients, whatever, in your care with and under certain standards, and we do our own policing through our registered nursing association. We are accountable and make sure our nurses are current and licensed etc. I guess when you see legislation that comes along and tells you exactly what you're supposed to do, or legislation that points out things you do in ordinary practice, I guess is what I want to say, it is a demoralizing issue for us.

Certainly, anybody who would talk to nurses—we're not above auditing ourselves and making sure we are giving the best quality care to residents, patients, whoever they are. That's, I guess, where we are coming from.

Mrs O'Neill: Do you want to give one small example that popped out when you read Bill 101?

1720

Mrs Doyle: Just that it talks about care plans. These are basic nursing ideals that we do. Every resident, very patient has a care plan. In long-term care especially, we try to involve an interdisciplinary team approach to care planning. In fact, just to say they should have a care plan doesn't really cover our standards at all. The care plan should be interdisciplinary and should involve the resident and the family, and the goal setting should be done in concert with that resident and that family.

Mrs O'Neill: Thank you for being so specific.

Mrs Doyle: There are others.

Mr Owens: Thank you for your presentation. It's groups like yours that have worked so hard to bring the specialty of gerontology to the forefront and doing the good work in terms of how we look at our aging population and taking the holistic approach we certainly need to take.

You raised a number of good points and, following on Ms O'Neill's question, I think the challenge is not only that a facility develop a care plan. You're absolutely right, in terms of standards of practice, any facility worth its salt would currently be doing that. I guess my concern is to ensure that the care plan is in fact actioned to the fullest extent envisioned by that multidisciplinary approach you envision.

It's been my experience in dealing with some concerns in my own riding that sometimes that does not happen. This stuff looks great on paper, that Mr or Mrs So-and-so will do this and engage in this activity and it looks wonderful, but in terms of it actually happening, there's some doubt that it does, which leads me to your point about the staffing levels.

I think it's an excellent suggestion that someone somehow undertake a study on what kind of staffing is actually required in facilities or in terms of the home care approach. Again, you hear allegations in terms of hard-tocare-for patients where, because staffing levels are low, security, locked doors and restricted privileges are used in place of staff. I think that's an excellent point that we take a look at: just exactly how we need to staff facilities.

In terms of your comments around the inspection process, I read and re-read the language and, in my view, it's in fact—I hate to use the word "benign" because it has certain implications. I think we've seen the results, in a rather spectacular fashion—what happens when processes break down in terms of the abuse at various provincial institutions; some nursing homes in Metropolitan Toronto.

I think this type of language needs to be in place so there's an ability for the government to act to prevent the kinds of situations that have in fact taken place. We're not imagining these kinds of situations. I still believe in my heart that people want to do the best thing and that in terms of the creative management capability, it should still play a large role.

This is, I guess, my second day on the committee and the comments I've heard to date are that people want to do that and people have no fear of opening their doors or their books to the inspection process. I think people like yourselves—and I worked in a health care facility for almost

10 years. It takes a special person to be involved in dealing with people, especially people living in long-term care facilities, whether they're older people or younger people who are disabled. I think the challenge, as the comment that I made to another person on tour, is to look at the staffing issue, to make sure these jobs are challenging, that they're well compensated, that the training is there and that the highest efficacy of care is delivered to these individuals.

It's associations like yours that are helping to push towards that goal. While there's probably not a question there, I just wanted to thank you again for your presentation and for your excellent work.

Mrs Dovle: Thank you very much.

The Chair: Thank you very much again for coming before the committee. We wish you all the very best and we also wish you bon appétit.

Mrs Doyle: Thank you very much, and you too.

The Chair: Thank you. The committee will now stand adjourned until 6:30 sharp when we will reconvene, and I do have to insist on 6:30—

Mr Hope: Stress the word "sharp."

The Chair: —sharp.

The committee recessed at 1726.

EVENING SESSION

The committee resumed at 1834

The Chair: Good evening, ladies and gentlemen. We begin our final session in Ottawa, I guess our fourth session since we arrived last night. This is the standing committee on social development. We're here to review Bill 101, An Act to amend certain Acts concerning Long Term Care in Ontario.

ROYAL CANADIAN LEGION, ONTARIO PROVINCIAL COMMAND, DISTRICT G

The Chair: We begin this evening with the Ontario Command of the Royal Canadian Legion, District G. We welcome you gentlemen to the committee. If you'd be good enough just to introduce yourselves for the committee and for Hansard, and then please go ahead and make your presentation, then we'll follow up with some questions.

Mr Jim Margerum: Okay. On my left is Ray Lapointe, the president of provincial level and national capital area Amyotrophic Lateral Sclerosis (ALS) Society, and on my right is Jim Mayes, the district veterans services committee chairman. I'm Jim Margerum. I'm the district chief commander and chairman of the Rideau veterans hospital/housing review committee.

The Chair: Please go ahead. There's always a bit of movement in this room, so don't let it bother you.

Mr Margerum: Our role and a bit of history on ourselves in District G, or eastern Ontario, which spreads from, to the north, Deep River, to the south, Napanee, and along the St Lawrence to the Ottawa River and back up to Deep River. We're the golden triangle.

District G veterans services committee is responsible for and obligated to provide an advisory-advocacy role for matters relating to veterans' care and wellbeing by:

- (a) cooperating with other committees of national and provincial veterans' organizations to monitor the activities and the care and services provided to veterans and their dependants by Veterans Affairs Canada and, in this case, the province;
- (b) representing the position of veterans and organizations who are involved to provide advice and/or make recommendations on the care and needs of veterans and their dependants residing in eastern Ontario and including the Outaouais region;
- (c) providing home and community services for older veterans and seniors in the community at large;
- (d) establishing and/or improving domiciliary and chronic care accommodations such as Rideau Veterans Home, National Defence Medical Centre, long-term care centres, nursing homes and semi-independent supportive housing accommodations that will meet the needs of veterans and all senior citizens;
- (e) any undertaking that will promote useful projects for veterans, their dependants and all senior citizens.

District G's record in eastern Ontario: Our 68 branches in almost every community and our 30,000 members are actively involved in providing funds, equipment, facilities,

programs and volunteer support to the following—the gremlin snuck in; the first one should have been "housing"; I apologize for that: Meals on Wheels; hospitals, medical centres; scouts, cubs, brownies and girl guides; youth and adult sports; provide canvassers or volunteers for fund-raising such as cancer or heart and stroke; seniors' activities; seniors' care such as foot clinics, transportation, income tax preparation; providing our branch facilities for community activities; members of boards of directors, committees, auxiliaries and sick visiting/shut-in groups of hospitals, youth and senior organizations, nursing homes and other charitable organizations, and other specific projects.

Attached to this brief is a copy of the branch profile survey covering one year, from June 1, 1990 to May 31, 1991, on the role we play and the impact it would have in our communities if we ceased to exist.

Our concerns regarding Bill 101 and long-term care in Ontario:

- (1) Eligibility and admission: We are extremely concerned that the provincial eligibility and admission criteria will supersede and override Veterans Affairs Canada Regulations Respecting Health Care for Veterans and Other Persons (August 1990 SOR/90-594). This is clearly indicated in the clauses respecting admissions in the Rideau Veterans Home transfer agreement dated March 25, 1992, and the new provincial standards for eligibility and admissions. Incidentally, we see no reference whatsoever to recognition of veterans' priority regarding long-term care beds.
- (2) Coordinate placement services in Ottawa-Carleton: We again are concerned that all levels of care provided under veterans' health care regulations and funded by Veterans Affairs Canada will be jeopardized by application of the provincial eligibility standards.
- (3) Closing of beds and lack of beds in northern Ontario: We have seen, since 1987, a reduction of veterans' priority beds from 2,050 to less than 1,100 currently. Although veterans are aging and their needs increasing due to long-term effects of their participation in war and hostile action, it is incomprehensible that priority beds available should be reduced by 50%.

While we understand the concept of returning residents/patients to the community, we do not believe that the community has adequate domiciliary facilities, support systems and health care providers. Where will the veterans go? We are convinced that the province of Ontario, in accepting the transfers and the funds provided by Veterans Affairs Canada or other federal government sources, has the responsibility and obligation to maintain and keep open all beds and that access to these beds and facilities be determined by veterans' health care regulations.

1840

(4) Special interest needs: Adequate facilities for special care and respite care for such conditions as ALS, as an example, and others are woefully lacking and we are concerned that Bill 101 and the provincial health care redirection does not specifically address such needs.

Financial or budget considerations: As taxpayers and residents of the province of Ontario, we are concerned that health care be provided and delivered in a most cost-effective manner and with the minimum of duplication. While we do not believe systems and programs are in place in Ontario to handle extended care requirements in the community, we want to cooperate and work in conjunction with the Ministry of Health and others to develop such an infrastructure and the necessary independent facilities for veterans, seniors and the less fortunate.

In closing, we wish to express our appreciation for listening to our brief and that you will consider its contents and the impact of Bill 101 on veterans and seniors.

The Chair: Thank you very much for your brief and also for the attachments, which I note for the record are at the back of your presentation. We appreciate very much your coming here tonight. I think this is the fourth Legion group that has been before us—Toronto, London and Sudbury—and we welcome your input. We'll move to questions. Ms O'Neill.

Mrs O'Neill: Thank you, gentlemen, for coming. I am very pleased that you outlined the activities that you're involved in in the communities. I think many people don't realize how widespread those are, right from the very young to certainly members of your own community and their dependants, and I must say you are always one for the other and even remember often those who went before us. I think we all need that reminder.

Earlier this afternoon perhaps you have heard the Rideau veterans' home was very much a part of our discussions as we talked about the long-term care facility that we're all hoping will meet its expectations. We've waited a long time in Ottawa-Carleton for the facility that will hopefully meet the needs of the veterans in this community.

I would like you to say a little bit more. Every brief has its unique component, and the one I think I'd like you to respond to, because we haven't heard much of, is the special interest needs. Could you expand a bit on the things you've said here in the brief?

Mr Margerum: Yes. That was an example, and I'll ask Ray to explain about ALS, but the special interest we're concerned about is, we're responsible adults in the communities and we see situations with duplication of facilities and we feel they should be amalgamated so that there's a cross-section of needs, not just veterans. We're looking at hard-to-house, battered women, special needs; that if the facility exists there to provide a particular service for veterans and would provide a service for special needs groups, this would be part of the operation. It would not be a single veterans' establishment, but rather a community service development.

Mrs O'Neill: That's certainly admirable and very characteristic. Thank you for helping us understand that better.

I'm very pleased that you mentioned northern Ontario, because we found when we went—and we only went as far as Thunder Bay and Sudbury and many people don't think that's really the north. We found there were very different needs than we have experienced in the more

southerly parts of Ontario. Do you want to say a little bit about why you found that it was important to mention the north in your brief?

Mr Margerum: Yes. This is a letter from Veterans Affairs Canada, and to give you a quick history, in 1987, there were 2,050 veteran priority beds in the province of Ontario. As of today, there are 1,072. That's a drop of 50%.

In London, the psychiatric institute is closing and it's transferring its patients to either Western Counties wing or the very severe cases are going to St Thomas, I believe, to a little more capable facility. That leaves roughly 160 beds that are empty and no where for people to go. We feel that because of the age of the veterans, 75 years old—and what's the average life a person lives to, 80?—we have four, five or six years to solve the problem for our veterans, and we feel that those 150 beds, or whatever we can get, should be dispersed across the various communities in the north.

To do it fast and to have them operational, they could be attached to existing facilities that have a good track record and reputation, or beds that are closed could be opened and adapted to provide the services. It could provide some employment, and the cost would be minimal as far as additional staff is concerned. It is the only way in which we're going to resolve the problem for these veteran priority beds and the needs of veterans.

Mr Jackson: Jim, I appreciate your brief and the candour in which you've presented it. Here, in the situation in Ottawa, you don't have a veteran's hospital per se, and that's not been a reality for you. In fact, most veterans go to the Perley Hospital. Have you been involved or has anybody consulted your organization with respect to the reclassification of the beds and some of the discussions around reduced access to those beds?

Mr Margerum: That was the start. In 1985, when I was first approached to get involved with the Perley Hospital, I received a letter from the chairman of the board of the day. By 1987, I was asked by the dominion president and the provincial president to set up a committee to look into and push and pull the various bureaucrats and politicians to try to get a facility.

Everything sounded great. It's been going along. We were assured in a letter from ministers of the province and the federal government that by December 1992 we would walk into a hospital and our veterans would be housed. This is the current status of the hospital. It would be a hell of a job putting 250 veterans in that peg. That is the commitment. That is our concern, that veterans have been used as pawns in trying to get this agreement together, which is the final draft of the transfer.

That money was there at the federal level, and it's been sitting in a bank. I don't know if it gathers interest, but the veterans have been doing without. We are totally dissatisfied with what? With the promise in the first agreement, the draft agreement from Veterans Affairs Canada, and what we have there. What we have was the start of what you call level 2 beds and chronic care beds, which would be level 3 and higher. There were 175 level 2 beds and 75 chronic care beds.

All of a sudden, on July 1, 1991, communication stopped. We were part of what were called the stakeholder—I think we were pegged to the stake, but we were called stakeholders—and we were supposed to talk on behalf of veterans. So we go to a meeting, and then of course after the meeting they go upstairs and make the decision. The consultation process was a farce. They've gone through two functional plan studies, and all these promises, all the commitments that were put in the original draft were removed in the final draft. We weren't given the final draft until after it was signed.

Mr Jackson: Can you be more specific about the final draft? That is from the—

Mr Margerum: This is the transfer agreement between the federal government, the provincial and Perley Hospital.

Mr Jackson: So at some point—when there was the change in government, around 1991, did you say, or 1990?

Mr Margerum: No. I hate to be vindictive, but what happened all along the process, it was like a baby: Every time there was a mess, she changed the diaper; every time there was a problem in this project, they changed staff. We went through three ministers of Veterans Affairs, six ministers of Health for the province of Ontario and we lost track of the—

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Mr Jackson: Yes, I read that portion in your brief and in this article by Rick Gibbons of the Sun, but we've been led to believe by Ministry of Health staff that veterans' concerns are being adequately addressed at the Perley. I'm left with an impression that that's not in fact true, that in fact the combination of this backroom deal for reclassifying the beds and the reduction in hospital level care, in concert with this legislation, which doesn't specifically reference any protection for the federal agreement on access for veterans—those facts are out of sync with what the ministry's trying to convince us as legislators it's actually doing.

Mr Margerum: They didn't convince us, and the record speaks for itself. The beds have been changed from low-level to chronic care in one sweep of a pen.

Mr Jackson: Mr Chairman, if I might then ask, there have been references made to the Perley situation. Could I ask the parliamentary assistant to the Minister of Health, who has been part of these discussions, to undertake some sort of report to this committee with respect to why the government has seen fit to structure the legislation and bypass the federal agreement, specifically to explain why the Perley Hospital discussions, which have been occurring quite secretively, did not include the veterans' interests when in fact they were led to believe they would. I frankly would prefer to get that as a statement from the minister before I'm subjected to 101/2 minutes of Mr Quirt's explanation of what he thinks has happened up to this point.

The Chair: Okay, to the parliamentary assistant.

Mr Jackson: I'm asking for-

Mr Wessenger: I'm going to reply to that—

Mr Jackson: Perfect.

Mr Wessenger: —because obviously Mr Jackson doesn't want to listen to Mr Quirt's answers on that.

Mr Jackson: I've been listening to the man for a month

Mr Wessenger: However, the reality is that the priority beds are protected in the transfer agreement between the—

Mr Margerum: Excuse me, sir. I don't agree.

Mr Jim Maves: Might I say something?

The Chair: Yes.

Mr Mayes: First of all, by way of background, I'm a retired public servant of the federal government. I was an arbitrator of contract dispute matters.

The assurances that are now verbally being given by the administrators of the Perley Hospital that priority beds are being protected and the veterans are still being treated and will continue to be treated under the veterans' health care regulations is not supported by the language of the final agreement. If a dispute ever arises or if habits change, the language of the transfer agreement is such that the veterans' health care regulations can be just set aside and the new standards and the admission criteria created by the province will be the only thing veterans will go in under. They will receive no priority, and that is our concern.

All the verbal promises in the world are not going to change the language of the agreement. The language of the agreement can be changed by mutual agreement of the three parties, and that's covered in section 59 of the transfer agreement. If they are willing to give us the protection they claim they are, let the three parties sit down and amend the criteria in the transfer agreement.

Mr Margerum: A word of further explanation: In the draft agreement, in which we were with the assistant deputy minister of Veterans Affairs at that level and we went through this agreement, it said the criteria for veterans to the new facility and the existing facilities were existing veterans' health care regulations This is the language in the signed transfer agreement. "For the Perley and Rideau Veterans' Hospital"—

Mr Jackson: You should indicate you are quoting directly from the agreement at this point so Hansard will acknowledge that. Then we will have it on record.

Mr Margerum: Okay, in quotes, "For the existing facilities there is a criterion that recognizes this." The kicker is:

"The admission process at the PRVH Centre shall be as follows:

"(a) In accordance with the provincial redirection of long-term care (LTC), the admission process to the PRVH Centre will be coordinated through the service coordination agency. The role of this organization, the admission committee of the PRVH Centre and the practices and procedures of the admission process shall be established in accordance with long-term care reform policies and guidelines which may be in place from time to time."

If they are telling us different, which they have in writing, it's not part of the agreement, and in the agreement they have a grandfather clause for people who are currently in the facilities to get in.

Now, the average life of these guys is three and a half years. The place isn't built. They haven't got a shovel in the ground. How many are going to make it into that facility?

They have four clauses and four references stating these criteria. They don't need that if they're telling us that the veterans' health care regulations are a priority. That's a load of crap from them.

In here they have a clause which stops all these letters and promises and verbal agreements, "Entire agreement," clause 57

"This agreement and any appendices, amendments or addenda executed by the parties constitutes the entire agreement between the parties and there are no other representations, written or oral, applicable to the subject matter hereof except as expressly set forth herein, or as may be hereafter set forth in writing executed by the parties to be charged thereunder."

I suggest to you what's in there is the Bible.

Mr Wessenger: I understand this is a signed agreement, or is this a draft agreement?

Mr Mayes: Signed.

Mr Margerum: Signed. By all ministers.

Mr Wessenger: And that language you find unacceptable?

Mr Margerum: Absolutely.

Mr Wessenger: The only thing I can say is that, as veterans, have you indicated to Veterans Affairs that this language is unacceptable?

Mr Margerum: Yes.

Mr Wessenger: Have they given any response?

Mr Margerum: They sent us a letter. It's not part of the agreement. They said they understand the level 1 could get in, and the letter from the province of Ontario from some of the staff stated that currently they see no reason why a level 2 or a level 1 person couldn't get in.

Our concern on top of that is, they are now converting 24 level 2 beds, which is low-level care, to heavy-care beds. That's 24 coming out of the system for our low-level-care residents. Where the hell are they are going to go? That building is paid for by \$36 million of Veterans Affairs money on behalf of veterans, and if those beds are going to be converted and you have no place in society for them to go to as domiciliary care, you shouldn't be taking the money.

Mr Jackson: They're defrauding the public. That's what's happened.

Mr Wessenger: Certainly I can assure you we are interested in protecting your priority access beds and I will certainly ask the ministry staff to take a look at the situation specifically.

Mr Margerum: This is Bill 101, the last copy we got, sir, and nowhere is the word "veteran" even mentioned. There's not one single sentence, not one word that refers to it. Yet those beds and the moneys from the transfer from the federal government were specifically for veterans' priorities. There's no recognition.

We are prepared and we've stated very clearly that we are there to help and to work in the community, but surely the work we do and what those guys did on behalf of the country—and the ladies—deserves the respect of this country and what was given in legislation by past governments should be adhered to and honoured by current governments.

Mr Wessenger: I can assure you that we'd be prepared to take a look at an amendment to that agreement, or the bill perhaps.

Mr Margerum: The second part of that is, we have attempted to meet with the Honourable Frances Lankin from the signing of that agreement, from July 1991. We missed the boat because she's no longer Minister of Health. We tried. We wrote letters to the ministers, to the assistants, to everybody to ask to discuss this. As of July 1, 1991, all of a sudden we were put on the stake, not stakeholders any more, and everything just went quiet. The agreement was signed. Then they had the gall to send me the agreement in the mail saying: "Here's the agreement. I know you'll be happy with it."

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Mr Jackson: Mr Chairman, I wonder— Mr Margerum: I'm sorry. I'm on a roll.

The second part that bothered us is the language. As an example, it said the liaison committee "shall" have members of veterans' organizations as part of the liaison committee. The liaison committee was a problem-solving committee. It now says "may" have.

Our concern is, who's going to appoint them, and are they going to be a rubber-stamp to whomever or are they going to speak up to defend the rights of veterans?

It also said during negotiations there would be an ombudsman there, a veterans' liaison officer. That was wiped out.

The low-level beds are being wiped out. There's no recognition in 101 of the veterans. How can we believe? We have to be cynical when you look at a picture like that after eight years and that much money and that's what you've got. These guys are 76 years old, and you look them in the eye and you try to tell them, "Hang on, George, we're going to get you in a facility." It's pretty damned sad.

The Chair: I think Mr Jackson has one last request or comment.

Mr Jackson: I appreciate that the parliamentary assistant has seen fit to look into this matter further and that he has discovered some new information and I appreciate his willingness to pursue it further as opposed to responding at this point.

I simply want to put them on notice, as my colleague Jim Wilson has, that it is our intention to place an amendment when we're in clause-by-clause, and I only suggest that because I want the government to know how deadly serious we are about responding to this legitimate request and are therefore serving notice that recognition of the federal agreement will be in this legislation as far as the Ontario Progressive Conservative Party is concerned. I hope the parliamentary assistant will communicate that to his minister so he knows that this will be voted on as an amendment and that all parties are advised that we'll have

to deal with it. I don't think we're prepared to deal with it in a casual way, and I appreciate that the government says it's willing to look into it.

I finally wish to close with this concept, that is, that we heard today there are six additional agreements currently being undertaken with chronic care facility hospitals in this province similar to the Perley. I think the comments the comrades have made tonight apply to those other six facilities as well, to the extent that they involve priority access for veterans, so I would also ask that those it does apply to also be given the same courtesy of involvement and not all of a sudden to be dropped from the process. I leave that for the government to respond to, and we in opposition will continue to monitor.

Mr Owens: My question has actually been asked quite effectively by Mr Jackson. I can tell you that if in fact your interpretation holds true, you've been quite polite about where the stake has been placed in this process. As a person who's been a member of the Legion for approximately six years, I'm well aware of the good works you do and the kinds of facilities you need in order to continue the care of the folks who served this country.

This may not be an appropriate question, but I haven't seen the agreement, either the draft or the final agreement, and I'm wondering if it would be possible for you to share that with the committee, because I'd certainly like to have a fuller understanding.

As I've mentioned to other presenters, this is my first week on the committee, and in Sudbury or Toronto the issue with respect to the beds being downsized in numbers was raised. It's an issue of concern for myself and the veterans in my community, the members of branch 13 in Scarborough, of which I'm a member, and I would appreciate if you could share that with myself and other members of the committee.

Mr Margerum: I have a copy with me.

The Chair: I hope for all of you that it's clear from our discussion tonight that by bringing the agreement here and reading it, and I think giving us a fairly full explanation, you have provided us, at least, in terms of committee members, with new information. I think both Mr Jackson and Mr Owens have indicated, and as the parliamentary assistant has said, that the committee is certainly going to follow this and undoubtedly we'll stay in touch with you, so that clearly the intent cannot be somehow to deny privileges which are there and are owing, and that I think we would all feel very much an obligation to ensure continues to be there.

If you would like a final thought or comment, please go ahead.

Mr Margerum: Yes. To impress upon you or to show you the concern we have about those 150 extra beds being spread across the north, I guess the best example is dollars and cents. I believe anybody who's an MPP who comes from Ottawa or Windsor or the north and goes to Toronto gets an allowance with which to obtain an apartment or accommodation. Is that not correct?

The Chair: Yes, that's correct.

Mr Margerum: Okay. I'll give you a blunt history. Today we got the news—our people who are in these facilities pay \$420 a month, a veteran on pension—it's now increased to \$541.50, a 27% increase in the cost of living. I ask you about the spouse who is out in the community on a veteran's pension of roughly \$1,300 or \$1,400, being a combination pension of a husband and wife. How the hell are they going to keep a house and the husband in the facility? And what about a person who has to come all the way from Sudbury to Ottawa to visit their kin?

Mr Owens: Or Sunnybrook.

Mr Margerum: Or Sunnybrook, from Hornepayne or places like that? That is the seriousness. We feel very strongly that if they were to provide what we call the 50-kilometre-radius rule, a centre there for 50 kilometres around would be municipalities where they could go to visit a relative, and the cost is feasible. It's the most economical way and, more than anything, it's the most expeditious way, because we don't have a hell of a lot of time for these guys.

If we will address it, we're prepared to work with the ministries of Health or Housing to help. We have Nevada funds that we can work on if we're given the authority to use them for that purpose. We have people who are on boards of directors at hospitals, homes for the aged and different societies. We're prepared to do our part, but we've got to get the legislation and we've got to get the cooperation of politicians and bureaucrats to put that into action, not yesterday or not six years from now, but today, and get it started. That's the summation I guess I would have.

The Chair: You've given us the challenge, and over the course of the committee's deliberations I think you've heard from a number of members that they intend to pursue that. I know you'll be as close as always to it and we'll try to make sure that something changes. Thank you again for coming before the committee.

HILLEL LODGE

The Chair: If I could just note for the members, there was some problem in communication and one of the witnesses whom we thought was not going to come in fact always was going to come. I apologize that there was some misunderstanding. With the cooperation of the Victorian Order of Nurses, the Arbor Living Centers and the Ottawa-Carleton Placement Coordination Service, I'm going to ask the Ottawa Jewish home for the aged, Hillel Lodge, representatives to come forward.

They originally were going to be at 6:30, and we've discussed it and it was just a problem in communication. I apologize for that, but the important thing is you're here and we welcome you to the committee. We'll get some more of that delicious Ottawa water set up there and some clean glasses. If you'd be good enough to introduce yourselves and then please go ahead with your presentation.

Dr Gary Viner: I'm Dr Gary Viner. I'm a family physician here in the city and have been for some 13 years. I wear a few different hats. I am, as I said, a family physician with an active practice here. I'm the new medical director of the continuing care centre of the Ottawa Civic

Hospital, a new ward that has been contrived for patients who are waiting placement at the Ottawa Civic Hospital and are classified as being at an alternate level of care.

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As well, over the past eight or nine months I've also been the chairman of a committee of the Jewish community here in the city, the Jewish senior services committee, which is an umbrella organization that incorporates the very stakeholders looking after Jewish seniors in the city, so namely Hillel Lodge and the Jewish family services agency, as well as the Jewish Community Centre.

My colleague is Stephen Schneiderman, who is the executive director of Hillel Lodge and who will speak shortly.

Our major concern with this legislation relates to the centralized nature of placement services that are indicated in this legislation. Here in Canada, in Ontario, we take great pride in our multicultural community, that we're not actually a melting pot community as those of the south are. As all of you I'm sure are aware, as we age, with declining faculties, there's a real tendency for regression. We certainly believe that the optimal setting for seniors who are in this sort of state is one that is as close to their specific ethnic background as possible. There's no question that there's an ideal sense of comfort there and familiarity.

One of the concerns we have as members of the Jewish community is the loss of control that we might have over those seniors who are unable to be placed in that sort of environment, and frankly, as a physician for a large number of seniors who require placement, you see that very clearly in the variety of different ethnic groups that we care for in the hospital.

The Jewish community in Ottawa and other major centres, as you are probably aware, has a very well organized infrastructure. We provide schools, we have our own social service agencies, we have a home for the aged here in Ottawa. We subsidize these services privately through private donations to the tune of hundreds of thousands of dollars. We have a great pride in being able to perhaps provide services and excellence to the general community, but it's very important to us that we do have some degree of control over the facilities that we do have, and it's very important to us that we have some degree of control over the placement of our Jewish seniors.

Mr Stephen Schneiderman: Mr Chairman, honourable members of the committee, I'd like to thank you for the opportunity to get to speak to you tonight. I know that you've been going since early this morning and you've probably heard most of it already.

I'd like also to say respectfully to the committee and to the government of Ontario, whatever political stripe you are, if you are not a member of an ethnic group, you really cannot fully appreciate what it is that is going on within the mindset of these different cultures. When you speak about the Jewish culture, people have different opinions or ideas as to what they are or who they are, and I will tell you, it is a very complex combination between religious affiliation and ethnic identity. You cannot really appreciate that unless you're a member of a group, and I don't want

to make a distinction with Jewish people as opposed to other ethnic groups. Other groups have a similar kind of experience, a similar kind of profile, if you will. What I do want to say is that with respect to placement coordination services, there is a question here of subscription and trust as to whether or not people will actually want to use a one-stop access point and go away from what is familiar.

Hillel Lodge exists for the Jewish community. I want also to tell you that your definition of "community" may be very different from ours, because we define our Jewish community as anywhere Jewish people reside in Ontario, and no other services for Jewish people are closer. It is not defined within catchment areas, it is not defined within rural or urban settings, and consequently, those people feel most comfortable in dealing with a group that they know understands their nuances, their idiosyncrasies, what we refer to as their "schtick." Placement coordination services are not going to be able to handle those kinds of things, not in the way that we would like them to handle them.

I would like to respectfully submit that I don't believe this is going to be a major place for change, this committee, but I would hope that it could possibly be a place for modification, and one modification that I would like to respectfully suggest is using the Jewish community as a partner. If we talk about change, you need instruments for change, you need commitment for change, and who is going to supply that? People, and people in an organized fashion. The Jewish community is not only well intentioned, but it's well organized and well prepared to meet its obligations. It always has, and it always will.

In that light, I'd like to suggest perhaps deputizing committees or using them as panels so that you can have one-stop access within their own neighbourhoods, their own communities. People will then be able to deal with situations on a more local level, and if there are any problems, again, pass them on. If anyone feels they've been treated unfairly, they can always go before a centralized placement committee and complain or take their case before that kind of committee.

I'd like also to talk about the primacy of the individual and, members of the committee, you're probably going to hear the same tune sung over and over again. We're also members of the Ontario Association of Non-Profit Homes and Services for Seniors, and the primacy of the individual has been a key concern of that association. We share that concern.

We feel that one of the things that has not been looked at closely enough is the whole concept of retrieval. With the kind of climate that Canadians have to endure, it's a very noble idea to keep everyone at home, but who is coming into homes for the aged and nursing homes and chronic care centres? People well into their 80s. Perhaps they need a refresher and a pick-me-up, and not to be kept at home for years on end, staring at the television set with maybe just a Meals on Wheels person dropping in once or twice a week or the odd telephone call.

I would submit to this committee, if you've ever been in isolation, you don't have any opportunity to talk to anybody, you start talking to yourself, and things start to deteriorate. There are very well documented psychological studies on what isolation can do, and when you begin to lose acuity with the process of aging, the onset of that can happen much more rapidly and in a much more devastating fashion.

I also want to talk to you about one other concept that PCS cannot really deal with, and that is the archaic design of many of our facilities. With the demands and the pressure of demand that's going to be placed on PCS to place people, it's going to have to fill the beds. People are now being referred to as "bed blockers," not patients or clients or residents any more, and it's starting to sound like Monday Night Football. It's a strategy session—"How do you move people down field?"—and it is becoming a matter of concern.

We have a lot of facilities that are not equipped, either, with separate areas for special care, and therefore people are going to be placed in a facility merely because they belong to the same ethnic group. I don't think that will work out very well. Also, the facility itself is best acquainted with matching. I don't think you'd want to match merely for the sake of matching; I think what you want is an accurate and a good fit so that people can live there for many years to come.

I'd like to thank you for listening to us. I apologize for any inconvenience with respect to the communications, but that was a personal matter and I beg your indulgence for that fact. Thank you very much.

The Chair: Thank you, and no problem at all. We're delighted that in fact you could be here, because quite frankly, we thought you would have a particular point of view, and while in some respects, yes, we have heard that in different ways, we haven't heard it in the way that you've expressed it tonight and I think that's particularly helpful.

We'll get right to questions. Mr Jackson.

Mr Jackson: First of all, I appreciate your perspective and your presentation. My Ukrainian grandmother resides in a facility, like yours, with the strength of your religious belief system, in Winnipeg. That's where my mother's family is all from, so I'm familiar with it in visiting my grandmother there.

The dilemma for us, of course, is that we have a system that's in contraction. I'm intrigued by your football analogy, because you're losing ground but you're moving down field. It's just backwards, if I can put a finer point on your analogy.

But the legislation says there will be no new facilities built. You would know the demographics of the aging Jewish population in relationship to the aging balance-of-Canadians population, and I'd hazard a guess that overlay isn't encouraging either.

Mr Schneiderman: Far from it. As a matter of fact, the population's disproportionately senior, and that has to do with the fact that there's just not as much replenishment. The birth rate is not quite as high. Something in the neighbourhood of between 14% and 15% of seniors in the Ottawa area are over 65, and we haven't got the most recent census but we've done our own preliminary investigations and the Jewish community in 1985 was appropriately 10,000. Today it's 17,000. That of course excludes

places like Cornwall and Kingston where there are small pockets of people as well.

But one of the follies people labour under is the fact that everyone here in this room's heard of Baycrest, and that's fine for Metro Toronto, but the world does not begin or end with Baycrest. We in this region have our own concerns as to the best ways to deal with multiple problems.

Mr Jackson: But it's conceivable, with the size of the population of Metro Toronto, that Baycrest, even with minor modifications, with a placement coordinating agency, would determine ultimately that it could continue to service residents from the Jewish community. This is not the same in disparate rural areas, and that creates a dilemma here, because we have heard from organizations—we heard from a group in Sault Ste Marie which runs a Finnish home for the Finnish community, half other Canadians. But I sense that that's not the direction you're suggesting moving in. Is it the case in your own home in terms of your population mix?

Dr Viner: The population of our home is currently, I believe, all Jewish. I don't think there are any non-Jewish residents

Mr Schneiderman: We've had on occasion one or two non-Jewish people, but what you're dealing with then is, if you start to go down the pipe with trends now, with intermarriage there will be people who have never actually taken on the Jewish religion who would feel very comfortable residing in that home.

Mr Jackson: I understand that. My mother's not Jewish, but she speaks fluent Yiddish.

Mr Owens: All mothers do.

Mr Schneiderman: Just enough to make you feel guilty, right?

Mr Jackson: But the point I'm wanting to get at is, you're really saying to us that for a variety of factors—your faith community, your diet, especially with certain practices within the faith, has a hierarchy and a response—it would be your hope and intention that you could do a better job for your residents if in fact that homogeneity is respected.

That is not necessarily the promise in this legislation nor the way it's structured. We're not sure, in the absence of any regulations that have been exposed to us, that we'll be able to satisfy the specifics of your request. I'm not saying I personally; I'm talking about the government, which is ultimately responsible for tabling the regulations.

I'm not having great difficulty with your request, but I just want to make it very clear for the record that that's what you're saying, because as each of the organizations that bring culture and ethnicity and language, we're getting a range of a cooperative relationship, a reasonable mix, a priority mix or exclusive. I don't wish to put a negative connotation on that; I respect what you're saying. I just want to make it clear for the record, and that the language of the bill or the regulations specifically would have to—

Let me get to the final point. If the government must hold to its position that it has to be on need, then it begs the question of, would you accept a resident or would you be willing not to have the bed filled and suffer the consequences of not getting the funding? That's perhaps an unfair question, but that is a logical conclusion to the question you raise if it's not satisfied by the government. You could say, "Okay, fine."

Mr Schneiderman: I'm respectfully suggesting, number one, to answer your question, that we would be prepared at this point, today, to accept anyone who would feel comfortable in our home. One of the differences you have to understand is that when you talk about a non-denominational service, it is not the size or type of cross on the wall. There are no crosses on the wall. That's one thing.

The other thing I'm saying, respectfully, to the committee is that the Jewish community is interested in being a partner in the process and avoiding all this work going through a central placement committee. We would be very happy to do the work and, if we cannot handle the situation, refer it back to central placement. That's all I'm saying.

Mr Jackson: I missed your point. I'm glad you clarified that because I missed it.

Ms Carter: I would want to pursue the same kind of point. It seems to me we have two things here that may seem to be irreconcilable but I don't think actually they are. The one is the fact that people should have choice and that we should be able to keep the integrity of the different ethnic homes and so on. The other is that we have to give priority to the person with the greatest need, the person who is at the top of the list as being an emergency and so on.

I'm quite sure that there's no intention in the legislation—and I think this will be made clearer as further material comes out—to restrict choice, that the intent is that the consumer's choice is going to be paramount when a person is being assigned to a particular institution, so people will be able to say. "I'm Jewish; I would like to go to a Jewish home." But when you say that this means they should do that at the local level, that may be true here, but in my own community of Peterborough, for example, there isn't a Jewish home. Sometimes the need would be to access the system on a wider geographical basis rather than the narrower one in order to be able to find a particular home that would be suitable for whatever reason. I think that works both ways.

Dr Viner: You'll quite commonly find that somebody from Peterborough would want to go to Baycrest, though.

Ms Carter: Yes, absolutely. I think we're all agreed that we have to have this flexibility, however it works in a different place, and that we also have to look at the question of need. I understand that it would be quite possible for somebody to be assigned temporarily to a home which was not the ideal place because that was where a bed was available and the situation could then subsequently be adjusted as maybe a suitable place became vacant in a Jewish home, whatever, and there might be somebody who needed the other place. So I don't think this is impossible.

Dr Viner: Speaking as a physician who watches people getting disoriented as they transfer from ward to ward or room to room in a hospital, the last thing you want to do is have somebody go from one spot to another or a short-term placement and then move on to another for a longer-term placement and as they deteriorate move on to

another. You end up with a perpetually confused individual as opposed to one who's stable. The more you move somebody in this age group, the more fragile they are, of course, the harder it is to retrieve them

Ms Carter: I think we all understand that, but the problem is, the more variety you have, the more difficulty there is in finding the right fit at the right time. I guess that's just an integral part of the situation.

Also, we did have a presentation from Baycrest and it was concerned that it was spending more per capita than would be provided under the new arrangements and that it would be red-circled. I think there again as a government we have to stick to the principle that everybody gets equal treatment in the long run but that communities and groups that maybe want to contribute something to provide a higher standard for their people I would imagine would be able to continue to do that.

1930

Mr Schneiderman: Can I just briefly comment? I know time is of the essence. One of the things that I don't believe has been looked at is, with smaller charitable homes etc there is an economically viable number. Forprofit people will talk about numbers. I've heard the number bandied about, and it started out in 1985 at \$60. Now it's talked about at around \$100. You have to begin at the least altruistic level, the most mercenary, businesslike way, to begin to look at something, that there is only so much of a revenue base you can get for every resident and it cannot be divided out proportionately, because of economies of scale, with staff. We have made this argument on countless occasions.

Therefore, if you have, for example, a \$90-a-day portion given out, if it's only times 48 people, you still have fixed costs and a necessary staff ratio for health and safety, infection control and supervision. It becomes an absolute economic nightmare to deliver services under such conditions. Therefore, what we have been told is that augmentation can be done with outreach services. That's not true. You're lucky if you break even on outreach services. What are you going to make, a \$3,000 surplus on Meals on Wheels? If you're dealing with a \$500,000 deficit, the numbers simply don't add up.

So there are problems in terms of when I talk about archaic design, that facilities are not set up properly and they're too small in some cases—and I'll stop.

Mrs O'Neill: Thank you, gentlemen. I know Hillel has a reputation that precedes it in the community. You've brought forward some very practical problems tonight and I think that's always very helpful. I think we have had quite a few interventions, mostly I think originating from me, regarding the terminology of what "community" is in the implementation of this legislation. I think we've had some guarantees, at least from staff at the ministry, that in a case such as yours where there are cultural and spiritual values involved, there would be a much broader definition of "community." I think your statements are very true, that people in Peterborough would no doubt be willing to go to another community.

I'd like to say a couple of things. Your statement about isolation really hits home very closely personally to me. You likely know that in this community last fall there was a major survey done in preparation for a publication of the seniors in Ottawa-Carleton. It came out in every single area of this community that loneliness was their first priority of concern. I was amazed at how consistent that was across the community, and I did attend a workshop that followed that survey. As I met the seniors, they all had a different reason for feeling lonely. Most of them were living on their own.

I'd like you to tell me, do you use a placement coordination in Ottawa-Carleton at all? Are you part of that, or do you do all of your own placement?

Mr Schneiderman: Essentially we do our own placements. However, we have worked with a placement service. Occasionally they will get a Jewish person and refer them on to us, and sometimes they refer a person who we really, at least at that point, could not help. It did not mean, because you were Jewish and elderly and were suffering from some kind of difficulty, that we were necessarily the best placement in terms of how we're set up. Some special care issues really hit home on that, and that's forming the cornerstone of some of our future planning in order to have a setting that is secure and somewhat separate from the rest of the population, because those people do regress and whatever is familiar in terms of cuisine and smells and symbols serves to at least keep them going for as long as possible.

We have worked with the PCS and we do work with PCS. However, most of our people, even if we report them to PCS, all knock on our door and they will take that route. I believe they will continue to take that route despite the legislation. We're just going to direct them back if that's the way it has to work.

Mrs O'Neill: You didn't specifically say that you felt facilities should have the right of appeal as well as residents, but I presume from everything you've said that that's what your intent is.

Mr Schneiderman: I think that's implicit, but what I was hoping is that we would not have to deal with that if we could initially do a screening interview orientation process. We do a very involved one at Hillel Lodge. People come for an entire day. We have our physician look at them, our nursing staff, our social work staff and our recrealogist. I meet with them. There's a whole day. They have lunch. They participate with the residents. We have a good opportunity to see how they like it and they have a good opportunity to see how they like us.

Mrs O'Neill: That's the trust we must have in the facilities that exist, in your methods.

The Chair: Thank you very much. I'm sorry that time is always speeding by, whether on a football field or any other place.

Mr Schneiderman: I appreciate it.

The Chair: Again, thank you very much for coming. We really appreciate it.

VICTORIAN ORDER OF NURSES, OTTAWA-CARLETON AND VON EASTERN COUNTIES BRANCHES

The Chair: If I could then call on the Victorian Order of Nurses, the eastern counties and Ottawa-Carleton, if you would be good enough to come forward. We want to welcome you to the committee, and thank you for allowing us to play around a little bit with the schedule. If you would be good enough to introduce your colleagues and yourself for Hansard and for the committee, then please go ahead with your presentation. Welcome to the committee.

Ms Diane Raymond: I would like first to introduce my colleagues: Charles Armstrong, president of the Ottawa-Carleton branch of VON; Jean Courville, who is our executive director of the eastern counties branch; and Heidi Jaeggin, who is a director of the placement coordinating service of VON, eastern counties branch.

Before I get into my presentation, I should say we've been here since 11 o'clock this morning.

The Chair: You deserve an award.

Ms Raymond: We're suffering a bit from the same thing you are suffering from and we know where you're coming from.

The Chair: Do you have a prognosis?

Mr White: Just imagine four more weeks of this.

Ms Raymond: Exactly. The other thing, though, that I think was great about being here was that we did hear some views that were completely different probably from what we have been feeling. It's a shame in a way that this sort of information can't be shared with many more organizations. It is a pity. As a veteran of the Second World War—I've got to get the right war in there—I was very touched by the presentation the legion gave, because I think there's a lot of my personal feelings that went along with it. That's quite aside from anything I have to say, other than to say we have not given you a long presentation, you'll be glad to see. I'm going to more or less read it, because, as I say, it's later in the day.

As president of the board of VON eastern counties, I greatly appreciate the opportunity to make this presentation to you. I do not intend to review or rehash the material that's been presented by the various interest bodies in response to the consultation paper, Redirection of Long-Term Care and Support Services in Ontario. We have assumed your committee has access to this documentation, and after listening to the first report we heard this morning, VON Renfrew, I know you have heard VON's papers. You have the VON background, so there's no particular point in my going chapter and verse. We fully support, however, the responses made by VON Ontario. We were able to make our own contribution to the position paper and we feel that the main areas of proposals that were of concern to us as a local branch were brought out in the position paper and other submissions.

Tonight I'm primarily interested in providing you with some background on the eastern counties branch and commenting on the concerns the board has—and if you realize, I'm talking on behalf of the board, which is the volunteer part of our organization—with the use to which the responses to the consultation paper will be put and to a ministerial remark that was passed on to us that said, "The institutional sector covered by Bill 101 may overwhelm the community component." This concerns us. We are a community component.

First some background on the now 80-year-old eastern counties branch of VON. We are geographically located on the southeast side of the province, bordering Quebec. This is the part of Ontario that never gets noticed. Our branch serves five counties, Glengarry, Stormont, Dundas, Prescott and Russell. Looking at the map, you will see that our land mass lies mainly between Highways 401 and 417. Within this area, we have one major city, Cornwall, with a population of plus or minus 46,000, plus an almost equal number within a 30- to 40-kilometre semicircle, because it ends at the St Lawrence, around Cornwall. With a total population base of approximately 160,000, you can see that the minimum of 50,000 is spread rather thinly through a number of small towns, villages and rural areas.

1940

The two active treatment hospitals in Cornwall and most medical specializations are available. There are three district hospitals, in Alexandria, Hawkesbury and Winchester, and clinics in other locations, so we are relatively well supplied with what one would call the medical needs. Residents in the county of Russell do use Ottawa hospitals, because physically it's close.

A remarkably large percentage of our elderly population is the third and fourth generation of their family. Many still live in the area in which they were born, some in the same house.

We happen to be well supplied with long-term facilities. Unfortunately, some of the extra beds are a long way from the home of the potential residents. To comment on some of the discussion we heard today, we do have in our long-term facilities people from the Ottawa-Carleton area, temporarily, till they can be placed back in the Ottawa-Carleton area.

In a section of Cornwall and in some of the towns and villages, French is the language in common use, particularly among the older population. We therefore provide our services in the language of choice.

The five areas have not had a large influx of immigrants, so we don't face the same kinds of problems that you find in Toronto or even Ottawa. In the rural areas there are pockets of Dutch and Swiss farmers. In the greater Cornwall area there are small numbers from various different ethnic backgrounds among the residents. There are relatively few elderly among these groups at this time, but this will come. No one particular ethnic group predominates.

There is also a large native population on the reserve on Cornwall Island. Part of this reserve is under the province of Ontario jurisdiction, part under Quebec and part is the responsibility of the United States.

Our principal community service program is the visiting nurse program. Over the past three years, we've averaged 100,000 visits throughout the five counties each year. At present we have a percentage breakdown of roughly 80% RNs and 20% RNAs on staff. These nurses work out of the main offices in Cornwall and from suboffices in

Hawkesbury, Casselman, Winchester and Alexandria—and I bet most of those names are names you've never heard. Phone, fax and routine visits by the executive director keep the activities of these offices coordinated and in step with our client-centred objectives. We have computerized all accounting, payroll, data assembling and reporting activities and continually investigate where and if new technologies can contribute to more efficient and cost-effective operations. You may ask why we've put this in the presentation, but we do want to draw your attention to the fact that we are coming from a reasonably knowledgeable, technologically up-to-date community.

We are proud of our professional staff. They are skilled and motivated and able to perform the multiple nursing procedures normally required of the visiting nurse. Through the use of funds received from memorials and other donations, we've been able to send nurses on courses, seminars and workshops. This means we now have a trained staff available to meet the growing special needs in our community for palliative care, IV therapy, enterostomal instruction and support, post-chemotherapy and the highly specialized needs of infants sent home with severe medical problems.

We administer the placement coordination service for the five counties. This program has a community advisory committee chaired by a board member and through this the board is kept aware of PCS operations. PCS in an intricate part of any continuum of service.

The very obvious shortcomings in the present long-term care system identified in the consultation paper, such as fragmented, unequal or non-available supports, differences in eligibility criteria, confusing funding and resources allocation procedures etc, indicate that in today's society collaboration, coordination and cooperation are not only desirable but critical. Our support is for one long-term care policy, one that integrates both sections, community and institutions, with established policies and coordinated planning with appropriate organizational and operation structures. This of course means one ministerial responsibility.

We see a system based on a continuum model for longterm care as well worth a pilot study. We would be prepared to be part of this pilot study. Through the continuous process, the user of service-elderly or other qualified individuals-and service providers would have a system in place that moved logically and progressively from an entry point through a range of community-based in-home health and social services, from which selection based on need would be made, up to and including rehabilitation and institutional care where necessary. This could be the basis on which the now separate streams would become one. Through a continuum process, individuals would be able to have better control of their own care decisions and they would be informed of and able to select between alternatives with the knowledge that, if needed, the system has alternatives equally available and that they would have input into the choice of the alternative selected. This would strengthen their sense of independence and dignity. A further value of such a system is that it would overcome fragmentation but still allow for plurality.

We have one further concern, that is, that expediency, political pressure and funding problems may limit the time and resources needed to adequately review, compare and evaluate the counterproposals and alternatives received in response to the consultation process and the proposed amendments to Bill 101.

A move by government to proceed with hearings on Bill 101 before final decisions on long-term care redirection are made puzzles us. This moves flies in the face of government's stated commitments to full consultation, and, one can presume, examination of the responses, and a promise of a policy on long-term care. A policy to us means inclusion of all components of both the community and the institutional sectors, a policy that realistically integrates and provides control of fiscal and human resources and respects the rights of users and providers of service.

I'm going to turn over to Charles now, if I may, so you get both reports.

Mr Charles Armstrong: Thank you very much. I just wanted to take a few moments to perhaps update the committee on what's happening outside of Toronto at the number two VON branch in the province and some of our concerns. You're not really focusing as a committee on what's happening in the community tonight, but we're concerned, because what happens with the institutions directly affects our activities and we can see that in our clientele.

We keep talking about how long we've been around, and I want to reassure the committee that certainly the VON branches across Ontario are focused on the future. We've been around since 1895 and that's behind us and we're quite proud of the history, but we're looking at the future. We're beyond long-term care. I think, if we go back in history, VON really exploded when home care was brought into the province. It's probably the success of home care, which probably far exceeded your expectations and certainly VON's expectations, that is part of the problem in health care generally as we try to figure out how we can curtail the costs.

1950

Certainly VON, in a major market as we have here in Ottawa-Carleton, is directly feeling the pinch from the major acute care institutions as they cut beds, as they postpone receiving patients, as they send them home quicker than they did in the past. We see them, we've got major training, we're taking longer to see more acute patients. As they wait for beds in long-care institutions, they're becoming a more complex client base.

Just to bring you up to date on the size of the activity in Ottawa-Carleton, we see 1,000 clients a day. We are going around the clock, and certainly from a cost point of view, night-time we lose money, significant dollars, because you can't do it as effectively as you can during the day.

With restricted staff, you're driving further to see fewer clients. I guess, in total, we make 320,000 house calls on an annual basis—and I'm always looking back. The budget in Ottawa-Carleton for VON is approximately \$12 million, which is the size of many acute care hospitals across the province, and we do that with a very small management staff.

There are no VPs of this and that. I've been in VON a while, so I apologize if I sound proud of the organization.

What VON is focusing on and what our branch is turning itself upside down with is trying to curtail costs, because our fees have been capped and fixed. We are trying to change the mix of staff, to send out more appropriate staff to deal with the needs of the clients. Clients have a difficult time accepting that. We try to keep the press coverage down to a minimum amount. Through computers and voice mailboxes and fax machines in cars, as I say, we are redefining how we keep our staff employed.

The volunteer boards across the province, whether it's VON or the hospitals, the amount of time that we spend trying to figure out the various models that come forward for health care and prepare our position papers—it's just amazing the amount of time and effort that goes into that as we struggle through.

Change is coming and I want the members of the committee to know that we're prepared to assume a position, in whatever model finally emerges, as a partner, as a provider, or we're quite prepared to play a predominant role in being a coordinating group, if that were deemed appropriate.

By day, I'm a tax accountant, so I don't presume to advise a qualified committee on process, but I would certainly advise, if there are new models being developed, that we don't put it across the province all at one shot and that we do experiment and that we think it through. Certainly we do need some kind of coordination right from the major acute hospitals down to a foot care facility. The members of the community have to decide how they want their dollars to be spent. We do need a comprehensive policy, because what affects the institutions affects us.

I haven't thought it through all the way, but if we're really interested in controlling our costs as a group, and your costs and the province's costs, certainly the envelope approach has its attractions. I don't know how far you go with the envelopes, but that's an approach.

We are operating under a fixed fee. Every time we see a patient, whether it's an hour or two hours or three hours, or 4 in the morning or 9 in the morning—and certainly in Ottawa-Carleton we are pushed to the point where on a good number of the visits we are not covering our costs and we're at a very crucial point in our history. We are feeling what's happening to the institutions in our client mix.

Thank you very much. We are here to help.

The Chair: Thank you very much and in particular for a snapshot of what you are facing in your own areas. I don't know if other members are going to respond to the challenge to identify the various communities you mentioned in your comments, but when my relatives came to this country in the 1840s, they settled between Hawkesbury and Vankleek Hill, and the old farm is still there. So there's something in the blood that still responds to that call.

Mr White: My aunt lives a mile from Alexandria on the north—

The Chair: This could get bad. We could start a whole series of things here.

Mrs Caplan: We are very competitive.

Mr Owens: Representative, Elinor, representative.

The Chair: To get us back on track, we'll start the questioning with Ms Fawcett.

Mrs Fawcett: Thank you very much, Mr Chairman. My uncle drove ambulance out of Morrisburg to all of those places.

As I said this morning, the VON invented home care, I'm sure of it, and certainly with all of your expertise—and I experienced some first hand when our son broke his neck and we had the VON, thank goodness, coming in every day, because it took me a few days to get accustomed to that lovely halo that he was wearing for three months.

Certainly we appreciate all of the work that you do, but it is serious in rural Ontario, and I think you alluded to some of the problems that you are experiencing: lack of funds and yet the increase in numbers of people who need the care. Do you see a crisis looming, when we know that the number of seniors is increasing by leaps and bounds, and especially the more acute care people? I just wondered if you would like to expand a little bit on that.

Then, you were here maybe this morning when I alluded to that program on W5 where Saskatchewan VON is no more and I'm very concerned about that. Hopefully, I would like to see you take part in that pilot study, because I think you have a marvellous network. You are all over Ontario. You would be able to really give us a good idea of what works and what doesn't in all sections of Ontario. I've loaded you with a few things there, but—

Ms Raymond: I'm going to ask our executive director to speak to the Saskatchewan situation because she is relatively more knowledgeable about it than probably anybody in this room.

Ms Jean Courville: I was working with the Regina VON back when it had the home care program and then it was taken over by Wascana home care program when the government put in a new program. I don't think it was the Saskatchewan government which now chose not to contract with the VON in Regina; it was the Wascana home care program which did that. So I don't think it really matters which stripe they were wearing at the time; it was the local position that they did it in Regina.

The other programs, I think, in the west have basically lost most of the visiting nursing. It doesn't mean that VON won't be in Regina; it just won't have visiting nursing. There will be other programs that they will have to develop.

Mrs Fawcett: What would they be doing then?

Ms Courville: They could be doing a lot of things. I know in Prince Albert they are into occupational health in the north. Moose Jaw is doing things with education of health care aides and people working in the home, like homemakers, doing education programs there. I think that some of the other areas that they may be developing may still be out there, and Regina would be doing some of those things as well.

Mrs Fawcett: But I think we would agree that if we want this long-term care to work here in Ontario, you are a very integral part of that, making it work.

Ms Courville: Certainly, and I think that VON certainly has changed significantly over the 95 years that it has been in existence, and I know that—and I know Charlie mentioned this before—we will be changing in the future, and that's part of what we're ready to do.

Mrs Fawcett: Just briefly, I'd like also to mention I was glad to hear you refer to the native population, because we haven't heard too much about that. I know we are awaiting a study from the advisory—

Ms Raymond: We were just saving—

Mrs Fawcett: You don't have to touch it.

Ms Raymond: We were just saying today that one of the problems, of course, is the time that a nurse has to spend with a client. Jean was saying that we have one patient on the island, three hours, plus the fact that they've got to go over a bridge, pay a toll, which we do not get reimbursed for, and come back. So we're thinking now of asking for a reimbursement on tolls, but we'll leave that out of this.

But what I wanted to get back to is your comment about, did we see a crisis? I don't think we see a crisis. I don't think that's the way we work. I think we see there are problems and I think we see there are solutions, and I think what we have to say is, let's get the problems out and let's work on the solutions and let's stop all this pussyfooting around, passing the buck here, there, elsewhere.

I can say this because I'm coming from years and years, and I won't be here, probably, to see what finally ends up. Oh yes, I will. I'm going to live to 105, I might warn you.

So I don't think we have a crisis, but I certainly think we have some problems that have to be looked at and dealt with. I don't think VON has all the answers but I think it has some large hunks that it can put in there and hopefully do the job.

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Mrs Fawcett: Sounds to me like that ad, "Just do it," is what you're suggesting. thank you.

The Chair: We want to be careful about tolls. That could lead us down all kinds of funny roads.

Ms Raymond: Oh, I know.

Mr White: I want to commend you for your presentation. You do it with a little bit of humour and a real strong sense, I have, of your service in your community and your pride in what you have done. I want to say you're right, we should be going further. When you say it's expediency, political pressures and funding problems and all those other kinds of things, you're probably right too.

Ms Raymond: Unfortunately.

Mr White: There's only so much you can accomplish at one time, and I think we've done a tremendous amount with this bill. There is obviously, and has been, a stated commitment to go further in the very direction you're prodding us in and that you'll be on the leading edge of.

I just want to state very clearly that all of the VON presentations that we've heard—all 14?

Ms Courville: Only 14?

Ms Raymond: Well, there are 33 branches. You've got some more to come.

Mr White: I think there's probably more tomorrow as well. Every community we've been in we've heard two or three at least. They've all been not only excellent, and many along the same lines, the same themes, but also they all had those little unique twists that it wasn't like, "Oh gee, another VON presentation." It's like, "Hey, I'm looking forward to it, even though I've heard some of it before." I want to commend you and say, yes, you're right. You know, we're not going as far as we would like to, but we will be.

The Chair: Thank you again very much for coming, and if we were giving out awards for longevity in terms of being here all day, I think—

Ms Raymond: We're going to stay till the end.

The Chair: Very good. Thank you all for coming and being with us tonight. I'm sorry, was there anything else? Please.

Ms Heidi Jaeggin: As director of the eastern counties PCS, I would like to just bring something to your attention concerning placement of natives on Akwesasne, in our area, that's currently happening.

The current home for the elderly that serves that population is in Snye, Quebec. As you may be aware, the reserve cuts three jurisdictions; two provincial jurisdictions, Ontario and Quebec. It also cuts into New York state, and it has the US federal government involved and also the Canadian federal government involved.

The home for the elderly is in Snye, which is on the Quebec side, and the residents, whether they be Ontario residents or Quebec residents, access acute care predominantly in Cornwall if they're Canadian citizens. If they're American citizens they access acute care in Massena or in Malone, New York.

I understand there is a nursing home being built on Cornwall Island to serve the Ontario residents, which will certainly be an advantage, but right now the problem we're having is that, because of the violence on the reserve, the natives are not wanting placement in their own home for the elderly and we're having to look at resources not only in New York state but also in Cornwall and within eastern counties long-term care facilities.

We also have individuals on the reserve currently who, for example, are on respirators and total care whom we cannot place in either respite or chronic care and we are now having to access, certainly, Élisabeth Bruyère centres for these individuals, and they're natives. I realize that there's no native representation and it's becoming a real difficulty around Akwesane, specifically because of cigarette smuggling, and there is now a large number of incidents of violence on the St Lawrence River.

The Chair: Perhaps one of the things I might do, as Chair of the committee and through Hansard, is to send along what you have just related to us to both the Minister of Health and the minister responsible for native affairs. We know and mention has been made of a paper that is coming out with respect to natives, and I think to get that kind of input—they may well have received it through other channels, but I think having given it, and, as you

noted, we have not had native representation here today, you describe a very practical, day-to-day problem which clearly needs to be dealt with, and I would undertake to do that.

Ms Jaeggin: I think to access our services to the home for the elderly we have to go through customs, we have to go into New York State and back into Quebec. So there are serious logistic problems with border-crossing.

The Chair: Okay. Thank you for that information and, again, thank you all very much for coming.

Ms Jaeggin: Thank you.

ARBOR LIVING CENTERS

The Chair: I would now like to call on the representatives from the Arbor Living Centers, if they would good enough to come forward. We have received a copy of your presentation. Please make yourself comfortable, and perhaps you'd be good enough just to introduce yourself and proceed with your presentation.

Mr J. Michael Bausch: Thank you, Mr Chairman. I trust it's been a long day and I trust I won't keep you too long this evening.

The Chair: We're still very bright and cheery.

Mr Bausch: You're better than I am.

My name is Michael Bausch and I'm the president of Arbor Living Centers, which is a management company responsible for the provision of care and services to over 2,700 seniors in 17 nursing and 16 retirement homes throughout southern Ontario. Our client base includes both for-profit and not-for-profit providers of long-term care. Most of these facilities are in smaller communities, 10 of which are in eastern Ontario. Our comments on Bill 101 will be confined to our interpretation of its impact on nursing homes, although our experience in retirement homes also heavily influences our thinking.

I'd like to begin by applauding the current initiatives of the government of Ontario, for we believe the bill represents the first legitimate attempt to bring more equity in funding and regulation to all extended care providers through the province. It certainly has been a long time coming, but it's warmly received.

In addition to attempting to level the playing field, this bill proposes to fund all residents of all extended care facilities on the basis of demonstrated need without reference to the particular long-term care facility chosen by individual residents and their families. In your travels across the province, I'm confident that you've heard often of the historic inequity in funding levels among different types of providers and there's no need to belabour it further.

In addition, the bill proposes to apply universal standards of regulation to all types of long-term care providers, utilizing a common set of rules and inspection procedures. Once again, in enhancing consumer choice, it has long made good sense to ensure that all providers be held accountable according to the same rules, assuring residents and families that basic minimum standards are maintained wherever extended care is being delivered. In our opinion, this feature of the bill should be applauded by provider and consumer alike.

However, as you might suspect, we do have some concerns. These concerns largely include provisions which we believe could potentially limit consumer choice, could create additional inequities while removing historic ones and in general create a wide range of new problems. I'd like to concentrate on five elements, what I've labelled the contract, the placement coordinator, penalties and processes, quality assurance and resident councils.

It's our understanding that extended care has historically been an insured service in the province under the auspices of OHIP and that Bill 101 proposes replacing this insured service through contractual service agreements between government and providers. This is an extremely significant departure from historic commitments to universal and accessible health care in the province.

While at first glance contractual agreements appear to represent an efficient replacement for cumbersome regulations, the fundamental underlying assumption in any contract is that all parties accept certain responsibilities and failure to discharge agreed-upon responsibilities results in breach. Contractual breach leads inevitably to remedies available to the non-offending party vis-à-vis the party in breach. We can see little of these fundamental elements of contract in the bill. The responsibilities appear to largely incumbent upon the provider, with little responsibility in evidence upon government.

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More specifically, the bill eliminates all government responsibility to fund providers equally to ensure that the same level of services to all residents throughout the province is made possible. It would appear possible for government to treat different providers in different ways, funding some programs in some facilities while not providing these programs in others. We would suggest that the ultimate losers in this scenario are residents, those who are in effect being denied equal access to programs.

Additionally, there would appear to be no attendant responsibility defined in the bill for the government to fund requirements of extended care residents as determined by their assessed needs. The proposed resident classification system will be used to allocate available funds for nursing and personal care. Quality-of-life programs and accommodation will be funded using another, currently unidentified approach.

The resident classification system should enable government to develop a case mix system, which is a means of comparing one extended care facility to another and to determine how available funds will be distributed among all facilities. There is no guarantee that available funds, however, will match assessed resident needs, and, more importantly, no ability for facilities to react to inadequate funding levels is set out in the bill. To return to the contractual analogy, the ability to determine remedies in case of breach of contract on the part of government is denied and it would appear that the contractual service agreements are not intended to be contracts at all, as all remedies are reserved for only one party to the contract, government

Not only are contractual service agreements provided for, but also individualized care plans for each resident and a notice in writing to each resident describing services to be provided under the service agreement is specified. A further requirement is that the care outlined in individual care plans must be provided. Should government funding be inadequate, however, no flexibility is envisioned. One can only speculate as to the accuracy and detail of care plans, considering that there is assurance of financial resources sufficient to meet the needs of all residents.

The proposed legislation also seems to focus on process, as evidenced by paper trails. While no doubt facilitating the proposed inspection process, this represents a step backward from modern approaches to resident satisfaction. Instead, we would submit, the focus should be on outcomes as matched against resident needs as identified in care plans, for a rigid insistence on paper trails is translated into facility staff devoting increasing amounts of time to documentation rather than to direct resident care.

We would submit that the nature of the contractual arrangement envisioned in the bill is further compromised by the provision of immunity for all acts done in good faith by placement coordinators and inspectors while no such similar protection is provided for facility staff. In the interests of equity alone, similar treatment should be afforded to staff.

Finally, all contracts customarily provide for some form of arbitral process to resolve differences between parties, and in this bill no arbitration or appeal process is identified. Clearly, with government able to alter funding, to change policy and to redefine programming requirements, the contract is too one-sided. Some process enabling facilities to appeal disparities between government funding and government-mandated programming really must be incorporated, for to ignore it is to encourage behaviour adverse to desired outcomes and could ultimately result in extensive and perhaps needless litigation.

To turn to the placement coordinator, throughout the long and arduous consultative process surrounding reform of long-term care delivery, perhaps no item has been more contentious than the role of the placement coordinator or similar functionary under ever-changing titles. There does seem, though, to be general agreement among government providers and consumers that some form of central information agency is required. Far too many anecdotal incidents of vast confusion among residents and family members have been recounted to deny the legitimacy of this need.

However, there has been and continues to be great difference of opinion as to the amount of authority and responsibility which ought best to be vested in this position. We believe there are legitimate concerns that placement coordinators will literally be given the power to control individual lives.

The bill appears to provide for the placement coordinator to determine eligibility for placement in a long-term care facility. How will placement be determined if individual care requirements and preferences have not been determined? We would submit that eligibility for service is distinctly different from determination of requirements. As well, many placement decisions need to be made on evenings and weekends. Will the service be available 24 hours

a day, seven days a week? Will substitute decision-makers and responsible parties be identified prior to admission in order to minimize incidents of default in financial obligations and in the establishing of ability to pay? Perhaps most importantly, will the placement coordinator be required to consider applicant preference, be it geographic, ethnic or religious, linguistic or family-driven? These concerns simply aren't addressed in this bill, and they do represent continuing concerns as expressed to us as providers and through many other consumer forums, such as the seniors' alliance. Finally, will placement coordinators assume responsibility for discharge planning and the coordination involved when changed needs dictate movement to a higher level of care more appropriate to the resident?

Once again, to safeguard consumer choice, we believe some means of appeal of placement decisions must be incorporated into the legislation. This process must be timely, it must be accessible and it must be efficient, for typically at time of placement the need is acute. An unnecessarily complex process would not be in the best interests of residents and families.

As well, from a facility perspective, what assurance is there that an individual facility has the ability to meet the needs of the prospective residents? Currently, the facility administrator, the director of resident care and often the medical adviser are all part of carefully determining whether or not an applicant's needs can be met, where he or she is to be situated within the facility and, in cases of shared accommodation, how well the potential resident can be matched with prospective roommates. Health status, care requirements, cultural, religious and language factors are all considered.

We believe that individual facilities must continue to have the right to define their missions and the types of services they are able to deliver. The ability to refuse an individual applicant must be retained when the facility's mission, human and physical resources preclude the ability to meet residents' care needs. Particularly among ethnic and religion-specific extended care facilities, there is great concern about the proposed placement coordinator's ability to undermine their entire reason for being.

The need for an appeal mechanism, then, is equally demonstrated on behalf of individual facilities. Timely and efficient, a process whereby placement decisions may be challenged when the ability to meet the care requirements, both medical and social, of potential residents is compromised simply must be provided for in the legislation.

To turn to penalties and process, it would appear that the bill provides for a series of sanctions that government may use to penalize facilities if they are deemed to be in breach of contract. Without providing any similar penalties for government, these sanctions include reducing or withholding payment, freezing of admissions and suspending or revoking approval to operate. Tremendous power, then, would be placed with government to impose sanctions in an arbitrary and unchecked manner.

We would suggest that some of these strategies would be counterproductive. Particularly with financially driven sanctions, great care must be exercised to ensure that not only would the provider suffer penalties but what the likely impact might be on the rest of the residents. Once again, some means of appeal should be specified in the draft legislation in order to focus the penalty, to ensure that the penalty is applied in a non-arbitrary fashion and that the residents of the facility are not ultimately called upon to bear the burden. We would submit that, once again, the nature of the proposed contractual arrangement is too one-sided

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To those of us who have been involved in long-term care delivery for some time, it would appear that Bill 101 implies a return to an adversarial approach to inspections of extended care facilities. This despite the fact that government-commissioned studies long ago examined the effect of an enforcement or adversarial approach versus a combined consultative and enforcement approach. The Woods Gordon report of 1986 identified poor outcomes from the then adversarial climate between inspectors and providers. It was detrimental to problem-solving. It prevented the Ministry of Health from focusing efforts on the issues of greatest importance to resident health and safety.

The result of that study was a change in approach, resulting in a compliance management program that has proven to be very effective in monitoring resident care services and programs while facilitating problem resolution prior to the situation escalating to serious proportions. It is only after consultative efforts have been exhausted that enforcement has been invoked.

Bill 101 provides for a return to an older and universally rejected system. Inspection powers are clearly designed for worst-case scenarios. Broad powers are specified that would likely result in inconsistent and potentially unfair application of sanctions, and a return to an adversarial approach would likely mean a return to the period of increased litigation between government and providers, an unnecessary waste of valuable resources. The accountability of providers is not at issue; process is. This step backwards has no place in this bill.

Particularly when the impact and role of advocates with the passage of the Advocacy Act is considered, we would question the increased power of inspectors. What are these advocates for? Are they not to help improve communication and problem-solving? Are they not to intervene when residents' rights are being jeopardized? Why then the need for stepped-up inspection powers?

Bill 101 requires that each facility should establish quality assurance programs, and we assume this terminology is interchangeable with other, perhaps more in-vogue management processes such as total quality management. But of key significance is the lack of confidentiality in this clause of the bill. Quality assurance records, of necessity, in order not to subvert the desired process, must remain confidential. These records should be for the use of the facility in improving service levels, for most likely, commentary on staff will be contained therein, and the records accordingly should not be available to inspectors as part of normal routine. We would request that amendments to the draft legislation be made to reflect this.

Finally, residents' councils: We were most surprised to see no reference to residents' councils in Bill 101. The current Nursing Homes Act requires administrators of licensed nursing homes in the province to inform residents of their right to form a council and specifies its powers. No such similar requirement exists in homes for the aged, be they municipal or charitable.

While it is undoubtedly true that this requirement has probably not resulted in all nursing homes having an effective resident council, it most certainly has raised the awareness level of the place and the need for resident councils. Where resident councils do exist, and where nursing homes have assumed the responsibility of encouraging and supporting their formation, resident councils have proved to be an effective liaison between residents and management of the facility, and with the increased role of advocates in long-term care facilities, it would seem that the desirability of councils is strengthened, for advocates could act as a further resource and strength for the efficacy of these organizations. Failure to continue this provision in new legislation would represent a step backwards.

To summarize, while highly desired and long awaited, we believe the bill still falls short. The deletion of extended care as an insured service under OHIP and its replacement with the contractual relationship in the form provided will do little to improve the delivery of long-term care, for we believe too much power is reserved to government and its inspectors without corresponding accountability. Relatively little power, protection and/or choice is reserved for providers and consumers. Remedies for breach of contract by government are non-existent. Far too many issues are left to be defined by regulation and thus avoid legislative scrutiny, and facilities must provide for all resident care needs with absolutely no assurance that funding to support these needs, as defined by care plans, will be provided.

We would therefore strongly urge that Bill 101 be amended to provide for the following nine items:

(1) The government should be held accountable for the maintenance of equitable and consistent services in all long-term care facilities in Ontario.

(2) The legislation must not require facilities to provide all services as defined in care plans unless government assumes responsibilities for funding these services.

(3) Remedies must be provided to facilities in case of contractual breach by government in the provision of funding adequate to meet assessed needs of residents.

(4) Existing resources should be used for the placement coordination function and no new level of bureaucracy should be created for these purposes.

(5) Both applicants and facilities must have access to a timely and efficient appeal mechanism to challenge placement decisions by placement coordinators.

(6) The powers of government inspectors should not be increased and the use of the existing compliance management program should be continued.

(7) Sanctions for non-compliance should be reserved as a last resort and facilities should have the right of appeal of sanctions prior to their imposition.

(8) No member of any inspection staff should have access to personnel records or records dealing with quality review activities, peer review or performance review activities or quality improvement activities.

(9) Facilities must inform residents of their right to form a residents' council with specific powers, and facilities must encourage and facilitate the organization of these residents' councils and their continuation.

On behalf of our residents, our staff and our owners, I thank you very much for your time and for your thoughtful consideration of these issues. I'd be happy to answer any questions you might have.

The Chair: Thank you very much for a very full and clear presentation. We'll begin the questioning with Mr Jackson

Mr Jackson: Michael, good to see you. Thank you for a well-laid-out brief to the committee with distinct recommendations

I want to pursue a reference you make. It's been raised twice before, to my knowledge. I want to talk about a situation where a resident goes into arrears. There's nothing in the bill that assists a facility with that fact, yet it's clear that you can't simply discharge an individual, because as I understand it—I may need some guidance here from Mr Quirt—the placement coordination agency would be advised that this person is no longer paying. It's been documented and they now have to step in and find another facility where they can afford it. Is that essentially in rough terms how this system's going to work? I'd like to pursue this whole area, because in the absence of those kinds of decisions, what options do these facilities have?

The Chair: Can we put the question through the parliamentary assistant?

Mr Wessenger: Ministry staff can reply to that.

Mr Quirt: First of all, we don't envisage a situation where the resident wouldn't be able to afford the charge, because the charge will be established in direct relation to his or her income, but there are now circumstances where residents, for whatever reason, do not pay the rate that nursing homes or homes for the aged are entitled to receive from the resident.

Under the current situation, the only resource the facility has is to do its best to bring the issue to the attention of the resident, the resident's family or representative, and if that doesn't work, to take the resident to court and sue him for the maintenance arrears. That's a very difficult and uncomfortable procedure for any administrator to proceed with.

The current situation is as I've described it and there is no remedy to that situation in Bill 101. I would make the comment however that each facility is guaranteed a specified amount for accommodation regardless of the ability of the residents to pay either the \$26 universally affordable charge or the \$38 maximum. So the fact that residents wouldn't be in a position to pay or don't pay the rate they're required to pay is an issue not only for the facility now but for the province, which is obliged to make up the difference between what a resident can't pay and the rate of accommodation that the facility's guaranteed.

Mr Jackson: Could we explore that a little further, because maybe I'm not catching it. I'll just use lay terms, because then I won't confuse myself. You've got a resident in a home. All the workup's been done about their ability

to pay and a figure has been agreed upon. The province puts its contribution in and the resident theirs. Now the resident doesn't pay for whatever reason. The home still has to put food on the table, still has to provide the staffing. I'm lost as to at what point the province steps in and says, "Okay, you're not getting paid, facility, so we're going to make up the difference." After they go to court?

Mr Quirt: Under the current system, the province never steps in.

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Mr Jackson: I understand the current system. Under the current system, as long as they can find another placement, out they go. But my understanding is that what Bill 101 does is prevents them from making placement decisions. All placement decisions are made by the placement coordination service, and if that's the case, then is that not your interpretation? That's how I read it, that these recalcitrant residents can't be moved without the province's permission.

Mr Quirt: I think your assessment of the current situation is a bit off. It's highly unusual for a nursing home or a home for the aged to discharge somebody simply because they're behind in their payments.

Mr Jackson: I didn't say that. Until they find them another location.

Mr Quirt: No, that doesn't happen usually. They continue to care for the resident and they continue to pursue the issue of the maintenance arrears.

The Chair: I just want to be clear. As I understand what Mr Quirt said, in terms of the new system, there would be an obligation on the province working with the facility to make up that money, if that money wasn't there.

Mr Jackson: On the accommodation portion is what I heard.

Mr Quirt: That's correct.

Mr Jackson: But they're still having to feed and staff to the service level for the other two panels.

Mr Quirt: We would be funding that 100%.

Mr.Jackson: 100%?

Mr Quirt: Yes. We would be ensuring that each facility received a certain amount of money for accommodation for each resident, quite independent from an amount that has to be higher than the amount the resident pays for accommodation, higher than the \$38.

Mr Jackson: Is that in legislation or will that be in regulation?

Mr Quirt: That will be in regulation, because the figures will be changed annually as funding increases.

Mr Jackson: Okay. I've used up all of my time. I guess I'm trying to suggest there is an example that is not in legislation. Those contractual assurances will occur, but it's now relegated to the regulation portion. Although that's the intention, it may not be the contractual obligation. I'll wait till I see the regulations, but frankly I think that was one of the points you were making.

Mr Bausch: Yes, very much so.

Mr Jackson: I know I've used up my time, Mr Chairman, and thank you, but I wanted to understand that better, because it's the third time it's been raised, the concept of the financial obligations of the province here.

The Chair: I think that was useful to clarify.

Mr Owens: Turning to your section on penalties and process, my question is, first, how do you get recalcitrant homes to comply, and when they don't comply, what sort of penalties would you suggest be imposed in order to get their attention and force them into complying with regulations and other statutes?

Mr Bausch: In the first instance, what we're strongly suggesting is that this bill purports to throw the baby out with the bathwater. After a lot of hard work and extensive study, I think both providers and regulators or representatives of regulators within residential services branch would agree that today's system is much better than the system of five years ago, which is a combined carrot-and-stick approach, and we just don't see that reflected, that newer approach provided for in this bill.

I'm very much concerned that the sanctions provided for or identified in the bill are too much the ultimate, there aren't enough intermediate steps. It's too easy to say that there should be withholding of funds, but that's a very, very drastic step to have to take. Quite frankly, who is harmed by it? The provider clearly will be encouraged to exhibit different behaviour, but in the meantime, who picks up the food bills to make sure that the residents are being fed?

It seems to me somewhat analogous to drafting other laws and the penalties thereunder in a criminal sense. You must be very, very careful that you don't hamstring the regulator in giving him only extreme options to apply. I just don't see evidence in the bill. Perhaps, again, to return to Mr Jackson's comments, in general, in my opinion, there's far too much left to regulation and so it's left the bill open to misinterpretation which perhaps government did not intend, but my position is to try to point out where we have difficulty, not where we really agree with things.

You must have a gradation, in my opinion, of powers available to the regulator so that he can deal with situations as those situations dictate. Financial sanctions may be one of them, but that's pretty extreme, and I think you'd really want to apply that in the last case.

Mr Owens: In terms of the appeal process, what kind of amendments—I don't recall seeing anything in the nine points that you made—would you suggest to make the appeal process, in your view, work for both the potential client and the residence itself?

Mr Bausch: I guess it's probably easier to describe it in general terms than to be very specific, but there would have to be some sort of referee system that's virtually a ready response team. What I'm hearing from residents, what I'm hearing from residents, what I'm hearing from residents councils and various consumer groups is, human nature being what it is, people don't start into the process until the 11th hour. I probably wouldn't do it with my mom and I don't think you would either. You tend to exhaust all other remedies so that when the time has arrived it really needs to be done.

I would grant you that a very complex system right now would be simplified by this approach, and simplified greatly. But the desire is quite simply to be able to have access to a process where I, as the consumer, say: "I don't like the decision you made, Mr Placement Coordinator, what are my rights? What are my options?" The right to appeal seems to be fundamental in everything that we do in this society, and it's just not shown here. There would have to be a quick and ready response, perhaps through a referee, and if that's not satisfactory, I guess there'd have to be a longer unfolding process if you wanted to get it through. But what I'm hearing from consumers is, "Please make it quick, relatively quick."

I think from a provider's point of view, a similar instance. Two particular groups that we represent—one is a religiously oriented organization and one is an ethnically oriented organization—are absolutely terror-struck by the prospect of having to take in a resident who doesn't fit, in their terms, in one case from a religious point of view, in another case from an ethnic point of view.

This bill makes it appear that they would have to yield to the wishes of the placement coordinator, that's their fear, and if that's to be continued, the next step is: "If you're going to foist this on me, surely to goodness I should have some right of appeal. To whom do I appeal?" And again I would submit, although the provider might not be interested in due dispatch because he's trying to refuse to take someone, it's not in his best interests or the consumer's best interests.

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Interjection.

Mr Bausch: It may not be that simple. He may have an empty bed which he proposes to fill with someone of his ethnic persuasion, whereas the placement coordinator is saying, "I've got a much more pressing problem and I want to put in so-and-so." That's the concern.

The Chair: I'm going to allow Mr Hope a short supplementary because he's been patient all evening and this will be his last chance.

Mr Hope: I have been very patient all day. The questioning was going on around the penalty aspect—and you say we have to outline it clearly; if we put step 1, step 2, step 3, step 4 and the final would be cutting off funding—if we outline that, wouldn't that just encourage the process? The only ones who are going to be penalized are those who are the bad out of the category. The good ones will always try to rectify problems and I believe there'd be a cooperation there to correct the problems. But if we label each of the steps, wouldn't they just say, "Well, I don't need to comply with this, this is step 1, and I can go to step 2 or I could go to step 3 before it eventually affects me." Don't we leave an opportunity for more violations or noncompliance if we were to put the steps specifically?

Mr Bausch: I would have two responses, Mr Hope. I think the view is quite jaundiced, to be candid, because I don't think that's exactly what happens. I guess the analogy would be in the case of murder. If the only penalty is the death penalty, there really is very little option in terms

of reforming and making people change their behaviour, and I don't think the analogy is that badly based.

Mr Quirt's branch has had to operate under two different systems and I think he would have to agree that the current system, which provides for a carrot and a stick approach, has been far more effective. The stick still exists, but the carrot determines who needs to be whipped. There's a gradation of steps and it's just worked out very efficiently, at low cost. I suppose one might think in the interests of efficiency you should rush the judgement to the end, but you're going to get there soon enough anyway and a lot of good operators are not going to be unduly damaged by the process.

The Chair: We have to move on now.

Mrs Caplan: I would like to pursue this line because one of the opportunities that this committee has is to present amendments to the government or suggest ideas which hopefully the government will consider and bring forward its own amendments.

If we consider that the purpose of this reform is really to provide better access to care and choice in care to people in need of long-term care services, the question becomes, "How do you design a process which will achieve that result?" Your term "universally rejected system of the big stick," I think is quite correct, financial penalties penalize the residents, whether it's food or care or whatever. We know the huge proportion of the funds go to staffing and service directly.

One of the things we've been talking about here is an amendment that would mandate accreditation which would accredit both management and outcome; a mandate for a total quality management program or a quality management program; mandate a residents' council; and, mandate financial disclosure. That's sort of the mandate of the plan, but there's still not a stick there for the really bad apple which TQM and continuous improvement models say you look at what the result is, you become results oriented, but you still have to have a way of ensuring when you have a really bad situation that you can do something, because ultimately the government has to be responsible.

Are you familiar with the Public Hospitals Act?

Mr Bausch: No.

Mrs Caplan: The Public Hospitals Act has a provision, when the minister has cause for concern about quality of care—I believe it's section 7—whereby the minister can appoint, under that particular act, an inspector. Due process is then built in. Then a second step is the supervisor, and ultimately trusteeship occurs to safeguard patient care. That is the big stick, bad apple approach, but that's not invoked lightly, and what it does is it allows for a process that is very separate from compliance or support or anything else.

If you were to go with an accreditation which by regulation required all of those other good things that bring the values of quality management and continuous improvement on one side, would you be comfortable with a process such as the Public Hospitals Act kind of process for intrusion in a worst-case scenario? It would remove all penalities. What it would say is that if the home, if the

facility, is not providing quality of care, ultimately government walks in and takes it over.

Mr Bausch: That's a pretty stiff penalty. **Mrs Caplan:** That's a pretty stiff penalty.

Mr Bausch: You said it removes all penalties, it doesn't remove them all. But I happen to agree with you, Ms Caplan. Although I don't know the Public Hospitals Act, I do know the Nursing Homes Act, and what you've described, in my view, has been lifted from the existing Nursing Homes Act, and I think that aspect of the act and the regulations—and this is the point I'm trying to make to government—was a very positive change in nursing homes, and I think ministry staff would say that. I know the working relationship between providers and staff has vastly improved over that of five years ago.

Under the Nursing Homes Act, the Minister of Health has the right to invoke powers of trusteeship, and every nursing home provider knows that. But there are so many intermediate steps that can be taken. You don't have to, you can zip to the end, my understanding is, if it's deemed serious enough. If government does that, and it's done it haphazardly or arbitrarily, there are rights of appeal with the nursing homes review board to determine who did what to whom. I would assume there are a vast array of avenues of retribution available to the nursing homes review board.

Those are the good elements of the one act that Bill 101 proposes to amend that I can see as a provider of extended care services and nursing homes, and I would like to see it maintained. I don't think it needs a lot of tinkering.

Mrs Caplan: Last question?

The Chair: Brief.

Mrs Caplan: If you were to go with that kind of model, you could virtually eliminate the inspection and turn that into a compliance-education-supportive role for the ministry.

Mr Bausch: That in fact is the key aspect of the change that I've been referring to several times, that there's a group of people who act as consultative advisers—that's the carrot—and then if that doesn't work there are a bunch of enforcement people who come along and do the tough guy routine. That seems to have produced a much better system, in my view at least.

Mrs Caplan: The language of the old act has not been changed. That change has come without changes to the legislation. That's been by policy.

Mr Bausch: That's true. That came through regulation.

Mrs Caplan: So you'd have an opportunity here to write something new.

The Chair: I'm afraid we're going to have to close this off, and I apologize, but again, thank you very much for coming before the committee and for your presentation and answering our questions.

Mr Bausch: Thank you.

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OTTAWA-CARLETON PLACEMENT COORDINATION SERVICE

The Chair: I'd like now to call on the Ottawa-Carleton Placement Coordination Service, if they would be good enough to come forward. I want to thank you very much for being with us tonight. I must first of all apologize. Because of the vagaries of air travel, I'm afraid I'm going to have to leave. It's not because of anything you're about to say. I would very much have liked to have been here to hear your presentation and I do apologize the way the schedule has gone, but what is it they say, planes wait for no man and no woman? I will certainly read with interest what you have to say and will turn the chair over to Ms Fawcett, who I know will keep this motley crew in line.

Ms Suzanne Smith: There are disadvantages to being last and this is one of them, but I appreciate it.

The Chair: Thank you very much for being here, and if you would just introduce yourself, then please go ahead with your presentation.

Ms Smith: My name is Suzanne Smith. I'm the director of the Ottawa-Carleton Placement Coordination Service. My colleague is Lucy Carrière, the chief coordinator at the agency, and she's here for moral support and to help me with any questions you may have afterwards. I know it's late and you all want to go home, so my brief will be just that, brief.

As the director of the Ottawa PCS, I welcome the opportunity to respond to the amendments in legislation known as Bill 101. The Ottawa-Carleton Placement Coordination Service is an independent agency with a 14-member board of directors. Our board represents the various aspects of our community, both service providers and consumers, profit and non-profit. The Ontario association has also responded to the bill. My response will include comments as an association member and as the director of the Ottawa PCS.

To ensure that the consumer is best served, there must be a centralized, independent, objective, coordinated service available which has the responsibility and authority to assist consumers in obtaining the most suitable placement according to their needs. The amendments will streamline and amalgamate the current system for admission to longterm care facilities.

Placement coordinators would not expect to admit clients to facilities without considering all aspects of placement. This would include discussing with the facility representative any applicant whose needs may not be considered by the facility as appropriate for a current bed vacancy. Facilities should have the right to appeal any decision that contradicts those rights.

The intent to make long-term care equitable to all, particularly those who have been considered less desirable as residents and therefore denied access to the long-term care facilities of their choice, is a positive step.

We have concerns, however, that Bill 101 does not adequately address the needs of these hard-to-serve clients, particularly those who are physically aggressive. Clients are currently rejected because facilities are unable to meet their needs. Long-term care facilities will require

additional resources to meet the needs of these clients. It is therefore unrealistic to expect all facilities to meet all needs of all clients. There should be flexibility at the local level to decide which facilities could be designated to serve this population.

Bill 101 will allow adults with physical disabilities to purchase and manage their own services, a move which will support their dignity and independence.

Eligibility criteria must be precise and consistent throughout the province, but with enough scope to accommodate all potential situations. Furthermore, regulations authorizing admission to a long-term care facility must be equally clear. The immunity clause will offer little protection if such regulations are ambiguous.

Regulations regarding screening for infectious diseases such as tuberculosis, salmonella, hepatitis and HIV should be standardized. They should specify what testing is required, when it is to be done and/or repeated and who assumes the cost. Alternatives in case of client refusal should also be specified.

Clarification is needed regarding who and under what circumstances a person can give consent on behalf of the consumer for application or admission to a facility. Regulations should specify how and under whose authority information can be transmitted between long-term care facilities and placement coordinators.

PCS recognizes that an appeal procedure to review a determination of ineligibility is essential to our accountability. We recommend that notice be given not only to the applicant but also to his or her care giver or next of kin.

We support the presence of the placement coordinator at the appeal board as well as the powers assigned to the board. Hearings must be held locally and convened within a specified time in order for this review to be meaningful to a frail population.

We are extremely pleased that short-stay beds for respite care, emergency admission and supportive care are recognized as essential. If equal access is to be maintained, these beds must not be used as a way of securing a backdoor admission to a long-term care facility.

We recognize the right of the client to have a choice of a long-term care facility, particularly as it pertains to specific religious, ethnic, geographic and cultural preferences. The Ottawa-Carleton PCS always advocates for client choice. However, it is important to remember that choice is often dependent on bed availability and on circumstances. The current wait list in our region exceeds 1,200 applicants, with another 200 clients being assessed for placement.

Residential care within the long-term care facilities will at times be the most appropriate type of care for some clients. In the proposed system, this option would be limited to clients who can afford it.

With the authority given to the placement coordinator, there will be reliable and accurate data on bed usage and bed requirements throughout the province as well as standardization of the care requirements of consumers admitted to long-term care. In Ottawa-Carleton the PCS works in partnership with the community and all the facilities. This has been made possible through open communication and also because of

the composition of our board of directors. We hope that future boards will include the same broad spectrum.

In conclusion, I just wish to say that our PCS affirms a commitment to maintaining and improving our present collaborative working arrangement.

The Acting Chair (Mrs Joan M. Fawcett): Thank you very much, Ms Smith. You did keep your brief very brief and we appreciate that, but we do appreciate you coming, because I think, without exception, every brief has mentioned the placement coordination services as a concern and they would need a clarification. First on the list of questioners is Ms Carter.

Ms Carter: As our Chairman has said, this is a very central and important function of this whole thing and a lot of criticisms of the bill have focused on what they perceive to be the great power that is going to be in the hands of placement coordinators. They fear that this is just going to be uncontrolled, that people won't have choice, that their specific needs will not be met, that people will be forced on institutions that don't want them and so on. You have given us some very specific suggestions as to what you would like to see in the legislation, but how do you counter that broader argument that we've been hearing? Do you think that what seems to be a system that is now working well is suddenly going to become erratic and unfair and overpowerful? Has this been suggested?

Ms Smith: I don't want to sound naïve, but I don't see very big differences in the proposed system. We have always advocated for client choice, but I think we have to remember that choice is limited right now because of bed availability. We do approximately maybe 30 interim placements on a monthly basis. In the past, most of these placements would occur outside the region. We have worked very hard with facilities over the past years to get them to accept interim placements, and this has been very successful, so where we used to make 20, 25 interim placements outside the region, we now have perhaps five or six a month. We feel that it's better for a client to be in a second choice than to be placed 50 miles from his family.

Ms Carter: But earlier this evening, when we were hearing from people connected with a Jewish home, they were saying that if people are placed in what is an inappropriate home because they're at the top of the list, as it were, then to move them is very disruptive, and I'm just wondering what the answer is to that.

Ms Smith: I agree the move is disruptive, but it's also realistic. We have a lot of urgent placements. When you have a long waiting list and a lot of urgent placements, whoever's needs have to be met is the person who is considered.

In the case of ethnic and cultural issues, definitely we would continue to try and place these people in those facilities even if they temporarily have to be placed in another bed, and I think the short-stay beds might meet that need. It talks about a period of two weeks for emergency placements, which gives us some time to work out something else. We would never send a Catholic francophone to a Jewish home for the aged or vice versa, because this just wouldn't make any sense.

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Ms Carter: Yet this is the fear that we're getting again and again, that the distinctive nature of these homes is going to be eroded.

Ms Smith: I guess I don't see that happening in Ottawa-Carleton. I really don't.

Mrs Caplan: Every presentation we have heard has mentioned placement coordination services. Where they don't have them in practice, there are concerns and fears, and where they do have them in practice, we've heard consistently across the province that each of those regions had a unique situation because their placement coordination service was working really well and everybody liked it, which suggests perhaps that the fears can be allayed or that it's the fear of the change or the unknown, but I think the fear is real and we shouldn't ignore it.

One of the suggestions would be to have in the legislation a statement of principles that would guide placement coordination services. Actually, there was one service in London that presented to the committee, and it's available in Hansard, the statement of principles that guides it today. Although it is informal, would you be comfortable with a statement of principles in the legislation that would suggest that the sensitivity to multicultural and linguistic and social need was a guide, wherever possible, in meeting appropriate placement?

Ms Smith: Most definitely I would support that, yes; we all would.

Mrs Caplan: That might go some way to allaying the fears, I think, from what we've heard. You're to be congratulated, and the other placement coordination services. I know many of them are relatively new and some have been around for quite a long time, but it's been really a very good example of communities working together to meet the needs of the people they want to care for.

Just to switch very briefly, on page 2 of your brief you referred to, "Hearings must be held locally and convened within a specified time." From your experience, what do you think that time limit should be? We've heard everything from two weeks to 30 days. What do you think is reasonable to be able to provide appeal hearings?

Ms Smith: I would say probably a month. That sounds reasonable.

Mrs Caplan: You don't think that's too long?

Ms Smith: For the hard-to-serve clients, we sometimes have to wait six months now before we can place them, so I think a month is certainly very reasonable.

Mrs Caplan: I think we have a few minutes. We've also heard a suggestion that the facilities have the right to refuse on the basis that they can't provide appropriate care and that there be an appeal of that refusal. That's not in the legislation today. Would you support that right of refusal on the basis that the facility doesn't believe that it can provide appropriate care?

Ms Smith: Definitely, if it's well grounded, but I'd like to say too that one of our fears is that we are going to be told that we have to place people with aggressive

behaviour in a certain facility when we know it can't meet their needs

Mrs Caplan: Would you believe that in that case, there might then be—I had written it down here so I wouldn't forget. If you had to place somebody in an emergency situation, if the facility had a right to refuse, do you think the legislation might be helpful if it gave emergency powers, extraordinary circumstances that said that notwithstanding the right of a facility to refuse initially, until you could find a more appropriate placement, in an emergency you would ask them to take that patient? Do you think that would work or not?

Ms Smith: I think maybe it could work, but I would also like to say that perhaps additional funding could be made available to these facilities on a temporary basis if they accept to care for this person. Would you like to add to that?

Ms Lucy Carrière: When we talk about appropriate facilities, I would think we would probably have attempted to get that appropriate facility initially and I think these short-term beds would enable us to do that.

Mrs Caplan: As the legislation stands now, there is no right for facilities to refuse. If you were to add the right to refuse in an appeal process, that would add potentially a month, if that was the amount of time. So in an emergency situation, where you really felt that facility could provide the care, do you think then that the placement coordination service should be able to have an exemption from the facility's right to refuse?

Ms Smith: I think some facilities should be designated as specific to meet the needs of certain clients. For example, our chronic care hospitals could develop units to meet the needs of these people on a short-term basis.

Mrs Caplan: Have you participated in the role study that we expect to see in March?

The Acting Chair: I think we'll have to move on to the parliamentary assistant.

Mrs Caplan: That's a good recommendation.

Mr Wessenger: Thank you for presentation. I would just sort of like to explore some of your comments with particular respect to the hard-to-serve clients, as you call them. Right now, do you have certain facilities you have designated under the existing system that you will consider for those difficult-to-serve clients?

Ms Smith: No, we don't. It's very difficult to place any client with a behavioural problem. Usually they end up in acute care hospitals until their behaviour is under control or until they've deteriorated to the point where they no longer pose a placement problem.

Mr Wessenger: Do you think it would be of any assistance with respect to the long-term care facilities if there was some resource like a travelling team of experts to assist facilities in dealing with some of these behavioural problems?

Ms Smith: I think, yes, definitely. It does happen in some areas. I think that would be a good idea.

Mr Wessenger: The other thing I would just like to comment on is your concern about residential care, that at times it would be the most appropriate type of care for some clients and this option would be limited to clients who can afford it. First of all, I would just like to clarify that certainly it isn't just physical care that's going to be taken into account in determining eligibility. There will also be social aspects such as psychological factors that would be involved. But just as an addition to that, do you feel that it would greatly assist if there is much more substantial investment in supportive housing to provide other options?

Ms Smith: Definitely, ves.

The Acting Chair: I thank you for coming this evening and waiting very patiently, because I think, as your

brief has been, all the briefs we have had before us here in Ottawa have been very, very helpful to our deliberations and we thank everyone who has been before us.

I would like to remind the committee that the bus will leave at 8 o'clock tomorrow morning sharp, in front.

Ms Smith: Thank you. Thank you for being so alert too at this time.

The Acting Chair: Certainly I would want to say that we have received excellent hospitality here in Ottawa and hopefully we can return some time.

So 8 o'clock tomorrow morning. The committee stands adjourned and will resume in Kingston tomorrow morning.

The committee adjourned at 2108.





STANDING COMMITTEE ON SOCIAL DEVELOPMENT

*Chair / Président: Beer, Charles (York North/-Nord L)

*Acting Chair / Présidente suppléante: Fawcett, Joan M. (Northumberland L)

Vice-Chair / Vice-Président: Daigeler, Hans (Nepean L)

Drainville, Dennis (Victoria-Haliburton ND)

Martin, Tony (Sault Ste Marie ND)

Mathyssen, Irene (Middlesex ND)

*O'Neill, Yvonne (Ottawa-Rideau L)

*Owens, Stephen (Scarborough Centre ND)

*White, Drummond (Durham Centre ND)

Wilson, Gary (Kingston and The Islands/Kingston et Les Îles ND)

Wilson, Jim (Simcoe West/-Ouest PC)

Witmer, Elizabeth (Waterloo North/-Nord PC)

Substitutions present / Membres remplaçants présents:

Bisson, Gilles (Cochrane South/-Sud ND) for Mr Drainville

Caplan, Elinor (Oriole L) for Mr Daigeler

Carter, Jenny (Peterborough ND) for Mrs Mathyssen

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mr Jim Wilson

Rizzo, Tony (Oakwood ND) for Mr Drainville and Mr Owens

Villeneuve, Noble (S-D-G & East Grenville/S-D-G & Grenville-Est PC) for Mrs Witmer

Wessenger, Paul (Simcoe Centre ND) for Mr Gary Wilson

Also taking part / Autres participants et participantes:

Czukar, Gail, counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

^{*}In attendance / présents

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Deuxième intersession, 35e législature

Official Report of Debates (Hansard)

Thursday 25 February 1993

Journal des débats (Hansard)

Jeudi 25 février 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Président : Charles Beer Greffier : Douglas Arnott

Chair: Charles Beer Clerk: Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 25 February 1993

The committee met at 1032 in Howard Johnson Confederation Place Hotel, Kingston.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Acting Chair (Mrs Joan Fawcett): I'd like to begin so that we can keep as close to the schedule as possible, and call the standing committee on social development to order. We are dealing with Bill 101, An Act to amend certain Acts concerning Long Term Care.

I'm Joan Fawcett, acting Chair today for our usual Chair, Charles Beer, who had to go to Toronto for two important meetings. So I welcome everyone and say that we are very happy to be here in Kingston, and I guess I'm extra happy because I am a native of Kingston, having been born and spent my school years here in Kingston, and I'm always happy to get back.

ONTARIO COUNCIL OF HOSPITAL UNIONS

The Acting Chair: I think we will get right under way and call the first presenter from CUPE Local 783 to come forward—representatives, I guess I should say. If you would mind identifying yourselves for Hansard and then begin your presentation, and then there will be questions afterwards if that is okay with you.

Mrs Helen Fetterly: Good morning. My name is Helen Fetterly and I'm the president of CUPE Local 783 at the Cornwall General Hospital and an area vice-president for the Ontario Council of Hospital Unions, which represents 19,000 hospital workers across Ontario. With me is Sue Capido-Lambert from Kingston CUPE Local 1974.

We thank you for the opportunity to speak here today. We believe the restructuring taking place throughout the health system in the long-term care sector and as represented by Bill 101 has far-reaching consequences for us all.

In less than 20 years, the number of people 65 and older will have grown by 68%. While it is true that today's elderly will be the first to feel the immediate impact of policy decisions made with respect to Bill 101 and the restructuring of long-term care, future generations will also have to live with the consequences long into the next century.

The government has mapped out the route, but the road we're travelling down is taking us into yet another wrong direction. We have tried to respond throughout these many new directions, policy decisions and initiatives with respect to the massive restructuring of our health care system, but with each new twist and turn our concern only mounts.

Bill 101 fails in many of the same ways and for many of the same reasons that the government's long-term care initiative fails. That's because it is part of the bigger context of long-term care. As a result of this, the bill does not really take people into account and, when it does, undermines them by taking away their dignity, their choice and their guarantees to quality of care.

I will be commenting more specifically on the bill later in my presentation, but first I would like to deal with the overall direction of long-term care, of which this bill is a part, and examine some of the serious problems with it.

All parts of our health care system are vitally connected to each other. How can we come up with a comprehensive system that really works in the interests of people if we refuse to see it as just that—a comprehensive system? How can we entrust reforms in such a critically important sector to a government that does not even see the connection among the different parts of the system? For instance, long-term care is linked with acute care, chronic care, home support community-based services, mental health services etc. It cannot and should not be treated in isolation.

Close acute care hospital beds and services and chronic care beds and community-based home support services become crucial. Close chronic care beds and, again, sufficient home support services and beds in long-term care facilities become urgently required. Touch one part and the other parts are affected.

Insufficiently fund community-based home care services and we know with regrettable certainty that more elderly, not fewer, will present at acute care hospitals. This will put even more strain on hospital workers because of the huge layoffs and cutbacks in beds and services that are already taking place.

We have thought long and hard about why the government has chosen to proceed in this way, examining the parts of the health care system each in isolation from the other. We can only conclude that it is because it makes it harder for the public to see the full impact of the enormous restructuring taking place, and that's because this restructuring is really all about cutbacks—cutbacks in services, in people and in care levels.

Our health system is being fundamentally and irreparably altered in Ontario and this new system, the one we're working on now, will offer a much lower quality of care with fewer services and far less security to patients and to their families.

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I want to briefly point out what's happening in our health care system right now. It's instructive because it reveals the true nature of these so-called reforms. It shows a government that is in the process not of building an improved system of health care but of taking it apart.

Beds, front-line services and people are being slashed from acute care hospitals around the province. In another few months, more than 18 million paid hours will have disappeared from the system. Thousands of jobs have already been lost; thousands more are slated to be as the government continues its financial squeeze on hospitals. Its so-called reform in this sector includes shifting resources from hospitals to community-based agencies to allow for greater home care. In fact, the government has committed itself to transferring \$37.6 million annually from the provincial hospital budget to these community agencies. But so far, there has been no equivalent buildup of these. They are not yet in place. We don't think they ever will be. How and where will people get the care they need?

Despite the government's promise to maintain chronic care hospitals at their existing level of service, until the chronic care role study is completed, a number of these hospitals have been forced to close beds and restrict services to seniors and the disabled.

Why is this happening now? Does the government not understand that chronic care hospitals are in fact a vital link in the care for the elderly? They are not, I repeat, not glorified nursing homes. In fact, they provide complex medical care to people who require a variety of approaches which include rehabilitation, specialized nursing care, diagnostics—that is, intensive, professional care at a subacute level, and often for long periods of time. And they provide that care in a supportive environment.

The whole objective of a chronic care hospital's approach is to help patients return to their homes, if possible, where they can receive necessary community-based support services.

But there will always be a need for institutional care. People who become medically ill and unstable cannot be cared for properly either in their homes or in nursing homes and homes for the aged. Furthermore, the Council of Chronic Care Hospitals reports that these hospitals all carry long waiting lists, with many elderly actually waiting in acute care beds. Again, the clearly urgent questions that must be addressed are: Where will these people go? What will happen to them?

A fundamental link in all the restructuring taking place is the supposedly beefed-up role of community agencies providing increased home care services. But where are these services? What exactly has been put in place in the community-based sector to care for those now being displaced from acute and chronic care hospitals? The Senior Citizens' Consumer Alliance For Long-Term Care Reform notes that the government's hospital funding strategy will result in 3,000 to 5,000 acute care bed closures, and since seniors occupy 50% of the acute care beds, these closures will force tens of thousands of seniors to seek care from these community-based home care agencies.

So what's happening in the sector? We can't get any answers. Yet the government is proceeding to massively restructure long-term care on the basis that these agencies can and somehow will pick up the slack. Most people

would agree that the idea of allowing people to remain in their homes, in their communities, if they wish to, and receive the kind of care they need, is an attractive one. Most people would agree that providing these options and choices are positive, but that's not what's happening in this shift to community agencies. This shift is really about transferring resources to the community sector so that the underpaid, and in many cases inadequately trained, home care workers would provide services at a lower cost than in an institutional sector. That is, it's a cost- and quality-cutting measure. And more than that, choice and options are actually going to be reduced, not expanded, because the pressure is going to be on to provide care at home.

In view of the bed closures and cutbacks in acute and chronic care hospitals and waiting lists for beds in long-term care facilities, we are all going to be prevailed on to provide home care, like it or not.

The plan to move care back into the home will really hit women the hardest because we are still the primary care givers. This policy will, in fact, result in far more pressure being placed on women to either withdraw from the workforce entirely or carry a triple burden of responsibility.

It's difficult to listen to government rhetoric about its commitment to equality for women when it is initiating policies that have the effect of pushing us back into another century. Women are already vastly underpaid for their labour as it is. Now we are being pressured into filling in the cracks and holes of government policy, and manipulated into doing it for no pay at all.

This is wrong. It is regressive and it is an attack on all the hard-fought gains we have made over the years.

We seriously question whether the 600 to 700 community agencies can be efficiently organized to deliver good quality home care.

We see far more logic in expanding the role of hospitals and non-profit homes in the provision of community-based health care. Why expand the fragmented network of community agencies when hospitals and homes for the aged have a proven record and already employ a large pool of qualified health care workers? We have pumped billions of dollars into our institutions. It is far more constructive and efficient to expand their role into the provision of community-based services.

Although the consultation paper on long-term care devoted a full section to management of the system, virtually no mention was made of physician management of health care and, alternatively, ways to manage physicians. Like the Senior Citizens' Consumer Alliance For Long-Term Care Reform, we are astonished by the government's failure to examine the role of doctors in the referral to and provision of long-term care services. I want to spend a bit of time on this issue and on other money matters because in a very real way money, or lack of it, is very much at the root of all the restructuring decisions taking place.

Government policy and initiatives are being constructed out of fear. It's as if they looked at the population figures, saw the surging numbers of elderly coming up from the baby boom generation and responded prematurely, unnecessarily and irresponsibly, cutting services, budgets and people. We are absolutely incredulous at this response.

The government has at its disposal a vast army of bureaucrats, advisers and consultants who, had they taken the time, could have identified the huge area of financial waste in the system: billions of dollars that could have been, and still can be, redeployed to guarantee Ontario citizens a viable and quality health care system. We therefore observe that it is probably not the people power and expertise that is lacking, but the political will to take on certain sections of the establishment.

A huge portion of the OHIP budget, 76.1% in 1990-91, is spent maintaining physicians in the style to which they have become accustomed. Under the current system, most doctors are paid on a fee-for-service model. This system encourages unnecessary medical interventions because it rewards physicians each time a diagnostic test or clinical treatment is prescribed.

The fee-for-service system has led to a condition sometimes described as "revolving door" medicine. Since doctors depend on seeing a high volume of patients to maintain their incomes, the system in essence encourages doctors to overbook and, even worse, overprescribe. We believe this fee-for-service approach to health care is at the heart of our system's current financial woes and must be re-examined.

Payments to physicians, other practitioners and commercial labs under OHIP have almost quadrupled in the past 10 years to \$4.7 billion in 1990-91. Clearly, this end of the system is out of control. We believe it is imperative the government look seriously at reducing costs associated with physicians.

We recommend the replacement of fee-for-service by salaries wherever possible; the establishment of clinical practice guidelines, including the more appropriate use of therapeutic drugs, testing and treatments; an overall reduction in the number of practising physicians while ensuring the equitable distribution of doctors in all areas of the province; and greater reliance on non-physician human resources in both acute and long-term care.

We will not be able to truly reform any aspect of our health care system if we refuse to look seriously at the costs associated with physicians because it is specifically in this area that huge savings can be realized, and yet, as I mentioned earlier, neither Strategies for Change nor Redirection of Long-Term Care consultation papers dealt with these issues.

In addition, public hospital expenditures could be brought into line with the delivery of quality health care if moves towards democratization were implemented. We made these points in our submission to Mr Paul Wessenger's public hearings on the Public Hospitals Act.

Millions and millions of dollars could be saved annually by reducing waste and inappropriate utilization in the \$1-billion Ontario drug benefit program. The government's own program of drugs for seniors is one of the most serious causes of ill health among older people.

Finally, the rapid expansion and growth of for-profit service providers and commercial operators in health care must be immediately curtailed and reversed.

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We are extremely concerned about the growth of the private sector in home care. In 1978-79, the number of hours provided to Ontario residents was 82% non-profit, 18% commercial; in 1988, the ratios shifted to 62% non-profit and 38% commercial. At a CUPE health care conference, the Health minister at the time, Frances Lankin, stated that the ratio is now closer to 50-50.

How can we contain costs when health care dollars are fleeing the system in the form of profit? How in the world can this approach be justified, especially when money is tight?

Where does this leave us? First of all, it means that long-term care reform and the overall restructuring of a health care system is really being financed off the backs of laid-off hospital workers, underpaid community service workers, women and the elderly. It further means that there can never be enough money to deliver a sufficient quality of care in any part of the system because it will always be strapped for cash. We are already seeing the regrettable, predictable results of this type of approach.

As I mentioned earlier, as part of the long-term care reform, the government has committed itself to transferring \$37.6 million annually from the provincial hospital budgets, ostensibly for community services. This is absolutely appalling, especially when combined with the recent transfer payment allotment to hospitals that fell far short of the mark.

The concrete result of this type of approach means that more hospital workers will be laid off, more front-line services will be cut, less quality health care will be available for consumers and more and more strains will be placed on all parts of the system. It also inevitably means that the government will increasingly look to consumers themselves to help finance reforms. Again, we are already witnessing this.

As a result of the funding announcement which directly relates to long-term care facilities, the government is imposing a fee hike for many residents of nursing homes and homes for the aged. It is estimated that \$150 million of the \$200 million that will be infused into long-term care facilities will be raised from these increased user fees.

This is not the way to finance a long-term care system. It is our observation that user fees inevitably act as a barrier to accessing health care and are increasingly relied upon by the government to make up shortfalls in revenue.

Moreover, to support this long-term care restructuring, significant dollars will transfer from the non-profit to the for-profit sector as the government moves to equalize funding for all long-term care facilities.

The Ministry of Health announcements have assured the for-profit nursing homes industry that funding for homes for the aged and nursing homes will be equalized this year. This will likely result in less money for municipal homes for the aged.

Since the province is not planning to significantly increase its overall budget for long-term care facilities, this announcement implies that some money going to homes for the aged will go instead to nursing homes. We need to see more non-profit beds in the system, not less. We want

to see a more viable, publicly owned, not-for-profit, long-term care system. We believe this is in the best interests of the people of the province.

Serious problems with the underfunding of the entire health care system are also mirrored in Bill 101.

In recent years, the financial contribution by the provincial government for long-term care facilities has not kept pace with the increasing demand. As I mentioned earlier, because of the demographics and because of the severe cutbacks in acute and chronic care hospitals, we will need to see more money infused into long-term care.

But Bill 101 does not include any adequate funding commitment from the province, and worse still, as I mentioned, it shifts dollars from the non-profit sector to the for-profit commercial sector.

The province must make a commitment to provide reliable and adequate funding to the non-profit sector of long-term care facilities

In theory at least, there is something positive to be said about the role of placement coordinators in bringing some order to the system. However, in the reality of declining institutional care and the completely inadequate supply of non-profit beds in the system, there is a real risk that placement coordinators will become nothing more than enforcement officers, restricting access to long-term care facilities because beds are available in insufficient numbers.

The government must address the fundamental inefficiencies in the system and must ensure that more non-profit beds are opened up for people who need and want them.

The appeal process outlined in the bill is completely inadequate as a dispute resolution mechanism. It's not one that's going to be either effective or fair to an elderly person who isn't happy with their placement or, probably more to the point, lack of it.

People are often not happy in the facilities they find themselves in. They want to get out of a bad situation fast and they don't want to wait a month or more and, in the end, if all else fails, have to take on the government bureaucracy in court. We think the process outlined is an inappropriate use of government power, wielded against a single citizen.

That heavy-handedness is also apparent in that it allows one single member of an appeal board to constitute a quorum.

We hope these sections of the bill will be thoroughly redrafted and that it will be done in the context of more non-profit beds being opened up. It must also spell out that a consumer's choice of where she or he may want to live, in what kind of facility, must at all times be taken into account in their placement.

If the government is really serious about ensuring that standards in facilities are adequate and that residents are receiving the proper levels of care, then it must also incorporate whistle-blowing protection into the bill.

It is the residents and the bargaining unit employees who can monitor a service agreement better than anyone else. We believe they must be legally protected from any owner reprisals, and further that they accompany the all-too-infrequent inspection tours.

It is clear the ministry is not up to policing infractions. We have seen ample evidence of this again and again over the years. It is the resident and employees who have the greatest stake in well-run nursing homes and homes for the aged.

In conclusion, as I have outlined, there are too many questions still to be answered. Too many wrong initiatives and decisions have been hastily made and too little real consultation has taken place with respect to this incredibly important redirection of long-term care.

As it stands now, the system being put in place cannot and will not meet the needs of today's and tomorrow's elderly. On the contrary, it does a disservice to us all and seriously compromises a quality of care that we are all entitled to receive.

We sincerely hope the provincial government and the Health minister come to their senses, because unless and until they do, the entire system of health care delivery in Ontario will be placed at risk by foolhardy and wrongheaded policies that harm rather than help people in need of care

The decision is obviously the government's to make. We hope it will rethink its direction not only with respect to long-term care but also to acute and chronic care. We must slow down, take another look, reverse many of the decisions already made and engage in real dialogue in order to come up with a reasonable long-term care redirection that truly meets the needs of the people of the province.

The Acting Chair: I thank you very much for your very comprehensive brief. You have touched on a lot of areas and before I start the questioning, I'll welcome the member for—is it Prince Edward-Lennox-South Hastings? Did I get that right?

Mr Paul R. Johnson (Prince Edward-Lennox-South Hastings): Yes, you did.

Mr Stephen Owens (Scarborough Centre): That's a mouthful.

The Acting Chair: Mr Johnson, welcome to the committee. I'll begin the questioning with Mr Owens.

Mr Owens: In my former life as vice-president and subsequently president of CUPE Local 2001 at Toronto General Hospital, I'm acutely aware of the issues you've outlined with respect to hospitals and spending and other issues that have taken place under the former government.

I guess in terms of your comments on page 15 of your brief with respect to whistle-blowing, one of the things I've been concerned about is that for the week that I've been involved in these hearings, we've heard from a lot of providers. We've not heard from a lot of consumers. We've heard from very, very few groups like CUPE in terms of the current situation, and I think that from my view as an MPP in the riding of Scarborough Centre I can tell you that the current system is not working.

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There is little choice for people. We're involved in situations where a constituent calls me up and tells me that she's just received a letter from a nursing home where her husband is residing indicating that he's going to be tossed out a week before Christmas because they can't afford to

pay the bill, but my understanding is that we don't do those kinds of things. So, after a lot of negotiations, the individual is still there, but it doesn't address the issues that were raised by the nursing home.

So my question to you and to the Ontario Council of Hospital Unions is, we need that whistle-blowing protection and I agree. What kinds of suggestions would you make around amendments to this particular piece of legislation to ensure that workers from all levels of long-term care are protected if they come to my office or call the Ministry of Health or Ministry of Community and Social Services?

Mrs Fetterly: First of all, I'd like to deal with the issue of the whistle-blowing for the residents. It would be one of our ideas to set up some type of in-house committees, that the residents would have actually a president of a council and/or some kind of system or mechanism in place that they could go directly to their MPP and discuss these issues, because what's happening now, as you said earlier, there's no mechanism in place.

We've had a number of our people across the province who have their mom, their dad in these institutions being told they're having to get out within two or three weeks, a short period of time, and there's no place to put them, and if they challenge the system or do anything in a progressive way to do something, they are treated differently prior to leaving. Many times they have such a fear that they may not get into one of the other institutions that they tend not to do anything. The mechanisms—I think we would have to sit down and really think about how we could do this, how we could protect them, but I think first of all there would have to be some kind of council system or committee set up from within that sector to try to start to deal with some of those issues.

Mr Owens: The member for Oriole has talked a lot about accreditation processes as a way of ensuring quality care, and the buzzphrase that's being bandied about is "total quality management." In your view, coming from the health care sector and in my view, coming from the health care sector, I have a different view of how accreditation works in real life. Can you maybe share some of your experiences around accreditation in terms of the kind of protections that, in reality, you may or may not offer to residents?

Mrs Fetterly: Accreditations, coming from the hospital sector as a hospital worker, to us it's a farce. We see a lot of times, before the accreditation is taking place, out come the paint brushes, out comes the little bit of window-polishing etc and it's not worth the paper it's written on.

The second part of your question was—

Mr Owens: Was in terms of resident and staff protection and ensuring that residents are receiving optimal programming, that their interests with respect to health and safety are acknowledged. In terms of the staff—again I've only been on this committee for a week so I haven't had a lot of opportunity to hear other presentations, but health care workers themselves have some concern that the kind of work that one undertakes in the health care field, whether it's in an acute care setting or a long-term care

setting, is very heavy. There's a lot of heavy lifting and other issues that are related directly to the health care context.

So in terms of those kinds of issues in terms of the protection not only of the residents but also of the care givers, how do you view accreditation as assisting the residents and, again, staff in the current context and perhaps in the future if we were to take a look at that kind of process?

Mrs Fetterly: The current accreditation system is lacking a lot of avenues with regard to the health and safety of the workers. With regard to the workload, the workloads are far greater in not only just acute care but in the long-term care settings and the homes for the aged and municipal homes. They are put under a tremendous workload

They have, a lot of times, residents that are in the system because the active care hospital wants to get the bed empty. On many occasions, the records are sometimes "tampered with" in an indirect way. These residents get into these institutions and our workers, the front-line workers, are subject, on many occasions, to very aggressive patients and there are a lot of injuries.

The accreditation that is currently taking place doesn't lend a hand to any of those issues to help our people out there, let alone the residents of the institutions.

The Acting Chair: Thank you very much. I'll have to move on, being mindful of the time. Ms Caplan.

Mrs Elinor Caplan (Oriole): As the Chair said, the brief is very comprehensive and you've touched on a number of areas. There are a number of things that I disagree with and I think it's fair if I put some of that on the record, and some that I think we do come to a meeting of the minds on. I'd like to share some of that with you today as well.

The principle that I've always functioned on, on behalf of the public interest and the taxpayers, is that what's really important is value for money and that the objective should be, who can provide the very best quality care at the best price? I think that's in the public interest and the taxpayers' interest, as opposed to an arbitrary decision as to who the management should be. So I disagree with you, because I think balance between the commercial sector and the public sector is a better public interest model.

We've heard a lot of discussion about choice and flexibility and models for ensuring improvement in quality of care. There's a lot of new management techniques. I'm not going to go into that today, but I share your concern that this piece of legislation, being just one small piece, is moving ahead without the long-term care policy framework that has been promised for some time, that it's moving ahead without the chronic-care role study being complete, that there's no definition for a long-term care facility in this legislation or in any other, so we don't even know what we're ultimately going to be seeing at the other end. We heard in Ottawa from the Ontario Hospital Association about a number of redevelopment projects that are moving forward in the absence of the big picture, the comprehensive approach.

While I share your concerns for how that's all going to come together and fit together, I think that it is very important that the long-term care system be developed, because in my experience as a former minister, I know that we don't have in place a system now and that there's a lot of people—and that's what this is really about: caring for people—who are not getting the services that they need in an expeditious manner, not receiving appropriate care. A lot of that has to do with the fact that we don't have any kind of network in place to be able to respond appropriately. So this is just one step, but I would like to ask you some questions, if I have a couple of minutes, on the issue of alternative payment.

You spent quite a bit of your time suggesting that the fee-for-service system should be changed. There are a number of alternative payment models. Health service organizations are one, comprehensive health organizations are another, alternative payment for clinical teaching units in teaching hospitals and faculties of medicine is another, development of CHCs—community health centres—as well as alternative models of salary and payment within the health system. It's my understanding, anyway—perhaps you could fill me in—that pretty much all of those initiatives which were under way have pretty much—there's been a freeze on the shift to health service organizations, no substantial shift to community health centres. While there's been talk about CHOs, none is up and functioning.

Are you aware of any alternative payment plans that you've seen in this region? I know that Queen's University was negotiating an alternative payment plan for its clinical teaching unit in the teaching hospitals. Have you heard anything about that?

Mrs Fetterly: No. No, I'm not aware.

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Mrs Caplan: We see a rate of growth for money for doctors under OHIP going at 4% at the same as hospitals are getting 1% and, as a result of increases in money for doctors, almost \$500 million in the last couple of years, that's the rate of growth for OHIP. If you were giving advice to the government as far as setting its priorities and you had to make some choices because governing is about difficult choices, given the fact that you've seen them raising the rate of growth in OHIP, money for doctors at 4%, money to hospitals at 1%, nurses are losing their jobs because of that, what advice would you give them about where they should put available money or how to reallocate it as a part of the use of alternative payment? Should alternative payment plans be negotiated with the hospitals individually, in your view? How would you suggest that they do that?

Mrs Fetterly: I don't think we need alternative payment plans, my point being the overspending in the system. You talk about the drug benefits, you talk about the wages of the doctors; those are the things that have to be addressed. There have been many studies made throughout the province as to how percentages of seniors, 11%, 10%, come into hospital because of overprescribing. There are many, many areas in my brief that we could touch on, that talk about these issues that are real dollars.

Mrs Caplan: What you're proposing is just put all doctors on salary?

The Acting Chair: I'll have to end it there, I'm sorry.

Mrs Fetterly: Not necessarily. I said some of the doctors on salary were applicable.

The Acting Chair: I thank you very much. I wish we could go on, but we must try to keep fairly close to the schedule and I thank you very much for coming this morning and presenting those points.

HELEN HENDERSON CARE CENTRE

The Acting Chair: If the Helen Henderson Care Centre representative could come forward at this time. Welcome to the committee, and if you would take your seat and identify yourself for Hansard, and then begin with your presentation.

Mr Larry Gibson: Thank you very much. My name is Larry Gibson and I'm an owner and administrator of a small nursing home here in the city of Kingston. I also represent my family. We have another facility in Gananoque, which is not a large one necessarily either. It's a 93-bed nursing home and a 40-bed retirement home, so it gives you very close to what homes for the aged are today with the two levels of care and a continuum of care. The facility here in Kingston is a 42-bed nursing home and a 70-bed retirement home. They're all designed economy to scale.

In the initial stage when we started business—it's a family, as I say. It started in 1965, so we've been in the business for 28 years now. So we feel that we have a good feel for where we've come from and where we are today, as a family, and I can tell you that it's been a struggle right from the very beginning of day one in 1965, just because, as you know, in 1965 there were no rules and regulations for nursing homes and that the extended care act came out in 1972. So at that point in time, you were dealing with your local municipalities and of course they were different throughout the province.

Our facilities, as they started in the area, were to try to keep the seniors living in their area and not having to move. At that point in time, we had our homes for the aged in the area but they were in Kingston and Brockville, so anyone in between would have to leave their locale and that's why we have our one home in Gananoque. The facility here in Kingston was when there were two small nursing homes that were 19 and 23 beds and were not going to meet the rules and regulations in the province of Ontario as we progressed to today.

The owners at that time came to the family and asked if we would be interested in proceeding with buying their licences, as this seems to be the current way today. We bought the 42 beds and, of course, that's not a feasible size of a facility to give the care you would like to and also the amenities that would go along with living in a facility, so we added a retirement home as well, and tried to put some of the amenities that we felt that people, as seniors, would like, more of a home aspect rather than the institutional end. That's sort of how we've grown to where we are today.

Our facilities are accredited. Our facility in Gananoque has had five three-year awards. I guess we were one of the initial ones back in 1978 to receive a three-year award and we favour that system very much. Our background again is health. My mother was a registered nurse and it was her

dream to do more like convalescent care, but that has never really come into this province, where someone would be in hospital and not have to have the services after surgery, where it could be a little lighter in the environment. As I say, I think Belleville at one time with Dr Potter had a system similar to that, but it's never really taken off, so we ended up going into the nursing home end of it and it's sort of where we're at today.

We're strong believers in Bill 101, as with the Ontario Nursing Home Association. I think some of what I'm going to be saying is very much what some of you have already heard over and over. I'm a strong supporter of the association. My dad was president of the nursing home association in 1972 when extended care came in. So it just gives you a little bit of a picture of where the family comes from and our background.

It seems like a lot of Bill 101 is whether we're for-profit or not-for-profit and this is sort of where this has all come about, the long-term care reform, and I believe that there is a balance between both, as was said a few minutes ago. It keeps everyone on track and it allows everyone an affordable lifestyle for their needs.

I guess what's happened over the years, though, in 1972 when the extended care act was passed, homes for the aged and nursing homes were very much at the same rates with very little difference. But as you well know today, they are vastly different in how they've separated over the years just because there are different ministry responsibilities, one with the Ministry of Community and Social Services and the other with Health.

I think we all know that for the private sector it has been a struggle. Hopefully, those days will sort of end with the system as it comes aboard, so we support it very much. The seniors of Ontario deserve to have the same services, and the expectations should be the same in both, again in the institutions. I think only by going under this one umbrella, as we have today, we'll give them that right that is owing and deserving to them.

After all, they are our background for all of us who are here today in the room and there shouldn't be this discrimination as there appears to be, though, as you know, with the lawsuit that went on three years ago, it didn't come out as discrimination but it came out and said that the system was unfair and inequitable and that the government at the time should look at it and make it fair for all seniors of Ontario. I gather that's where we all are today.

Our facility, I can tell you, and why we're really promoting and looking forward to Bill 101 and the fair funding is that with the small facility we have with 42 beds and the 70-bed retirement home, my average rate for 1991 was \$66 a day. When you take the extended care portion and then you average what our retirement home rates are, \$55 and \$58 a day depending on your size of room, that gave me a \$112,000 loss in 1991. We're just now doing our books for 1992. As you know, Form 7 we'll be giving to the Ministry of Health very shortly, and I hazard a guess what our losses are going to be again.

Very similarly, what is happening is that the residential side carries the extended care portion, and the levels-of-care hopefully will change that. That same system of charging to the residential to carry the extended care happens in our homes for the aged as well. I know one of our own homes for the aged in the area here, a few years ago, went from \$61 a day to \$88 a day for the residential rates, and that was to carry the losses on the extended care portion.

This also is not just the profit side, but there are non-profit nursing homes as well in this province. We know that the Grove in Arnprior and Sherwood Park Manor in the Brockville area have had losses as well, so that the inequities of funding are for-profit and non-profit within the nursing home sector. It's something that is common to all of us who are in this area.

It's the homes for the aged that have been fortunate enough to have the other system, and also to have the backup of the municipalities that, if they do have losses, the city of Kingston for this area here would support Rideaucrest when they have a loss. We have none of those sort of backups. Again, this is why we support Bill 101. Hopefully, it will make the system equal and fair for everyone again.

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I guess what it also comes down to with this industry too is that we've had standards, we've had regulations, we've had inspections and we've had accreditation all along. This has very much kept the private sector in line to the needs of seniors and also with the Ministry of Health standards. The other sector has not had the same regulations and implementation. I sort of fear that's a part that the public sector worries a little bit about. What we've all had to go through all these years, they will have to go through the same sort of situation. It is very difficult living under these rules, but they have given us a very good service. I think the private sector has done very well.

It's like anything, though, whether it's private or public, there are going to be good and bad. I'm quite sure there are many of the public sector facilities I would not want to live in, and I know most of them, having been in the business for 25 years now. I pretty well know every institution within the province and you know there are 500 and some. There are places where you would like to and there are places where you would not like to. Hopefully again, what's fair for all would create a good environment and a safe environment for all seniors in the province.

I think with Bill 101 there are some concerns, though, in that the systems are changing again in the lines that we are going from an insured service to a contractual service, and that again will split where we're going to go because not all institutions or facilities will have the same. There again you are not giving the seniors of Ontario that choice of having a similar or same system. It's going to be different again.

I think in Bill 101, from what we hear anyhow, there is something that we're going to have within the facility that is affordable. We have to determine what services we're going to give all institutions and the expectation of the dollars has to go with that system as well. You cannot have a Cadillac system with Volkswagen dollars to go with it. There has to be a balance.

Another concern that we have, I believe, is that in Kingston and this area by the way, we are very much the strong supporters of a placement coordination service. We were one of the first. Kingston seems to be having a lot of the pilot projects. Home care was first here in the Kingston area. I sat on committees again with placement coordination and they support this area as well.

But it would appear that there may be a lack of choice with the way this system is going. Right now people do have choice and it works out very well with the present system that we have with placement coordination, so we're hopefully not wanting to have another bureaucracy where it would make it difficult to flow as we do in this area.

There's also no appeal for this as well. If institutions decide that they feel they can't cope with an applicant, and the placement coordination says they must, then you are going to have this particular problem where there is no appeal and you have to do it. There's no appeal, again, for families who maybe don't want to go to a particular facility, and we feel that the appeal system is very important as well.

Another area is that the compliance management program with the Ministry of Health is an excellent program. It's something that has evolved over years. We had an adversarial approach with implementing the Nursing Homes Act in the beginning, and it has taken all these years since 1972 to change it to the way we are today, where there's an excellent working relationship between—the lack of words, you hate calling people inspectors. They're more advisers, and they do come in and inspect, but it depends on how you want to use the words.

To inspect can be intimidating and I can tell you, in the beginning of the years, in our businesses when the word "inspector" was coming to the facility, people were on their toes. Everybody was very fearful of these individuals and wasn't relaxed, at home and comfortable when someone came into the facility, whereas today, it's a whole different approach.

The compliance operator comes in, it's very warm and friendly. Yes, she may find some things that are wrong, but that's what we're here for and it's done on a very cordial basis, and it's usually done with a shaking of hands rather than anger and hate and those sorts of things that went on in the past. So the system has changed and we'd hate to see it go back and regress to 20 years in the past.

I think the biggest thing we all have to do in this particular system is we all have to be accountable for our actions and accountable for the dollars that we were spending of the taxpayers. It's what's happening with the Ministry of Health at this point in time. It would appear that we have an open end and an insurance that goes on and on and on for ever and it can't. We cannot afford all of the things that we all like to think. There has to be some accountability, and I think that goes with our own facilities as well.

In order to save funds in the last few years with our two particular facilities, we went from an incontinency program that was disposable. We were also beginning to consider it was environmentally unsafe and trying to protect the future, but it was also more of a dollars-and-cents. We went with a reusable system. I can tell you, just within a 42-bed facility and a 93-bed facility, we saved \$61,000 by changing.

I know public institutions within the province that are still using a disposal system and are much larger than our 42 and 93. So you can just see that there is a lot of waste. I think we all have to look at all programs and see where we can trim back and cut back

There has been a study done recently with human resources in the Kitchener area where there was a comparison of registered staff within the homes for the aged and the nursing homes, and when you do see the results of these, it is on a two-to-one ratio. You're wondering why, if the nursing homes can operate the way they are today and give a very good service, then why are we spending more money in the public sector and not doing any better or any less?

I guess in conclusion what I would like to do, as you all have a copy here, is thank you for these few moments this morning. Again, my main concern is that the services of long-term care in the province of Ontario be the same for all recipients regardless of the long-term care facility they may reside in.

The Acting Chair: Thank you very much for your presentation. Now, if you would accept questions, I'd begin with Mrs Caplan.

Mrs Caplan: There are a number of amendments that the committee has discussed that Γ d like to ask you about. So it will be a series of short questions. Do you think an amendment that would allow facilities the right to refuse, on the basis that they could not provide appropriate care, would be a good one, and also a further amendment that would allow for a right of the placement coordination or the client to appeal that decision would be a valuable amendment in this legislation?

Mr Gibson: I think it would be very valuable. I can tell you in the small facility that we have today, I've had applicants who would come to us, and one of our main concerns would be safety of the resident where he would weigh 350 or 400 pounds. If I don't have the mechanisms to deal with or cope with this sort of need of a person, then I should be able to have the right to be able to say that I can't look after any one of this nature other than—again, what comes out of this levels-of-care is it allows you the funding to have the tools to do the job.

I mean, you can do anything if you have the funding to do this, but I also think that the families have the right to do it if it's a choice and a facility they like. They should be able, one or the other, to justify maybe why they can't and then come to an equitable reason.

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Mrs Caplan: There was one exemption that was discussed in Ottawa last night with the placement coordination people, and that was that there would be an exception or an exemption for emergency situations to that overall concept within the legislation. Do you think a facility, which might not see a long-term placement as appropriate, might be able to cope in an emergency situation?

Mr Gibson: Again, each incident will be an individual situation and I think they have to rule on an individuality basis. I think that given that it was short term, then one can see the light at the end of the tunnel sort of thing and you

cope with—we all have to cope today. I see that being very optional and again it's individual. I think most people are willing to cooperate and work together. It's when we get things in legislation that don't allow us, the sort of adversary approach, then it will break down all your working relationships.

Mrs Caplan: We've also been talking about a new model that would remove the 20-year-old, 1960s style enforcement that's in the bill as it exists today. What I've been suggesting, and Mr Owens referred to it earlier, would be a combination of an accreditation model on the basis of both management and outcome. You know accreditation has changed considerably in the last few years.

Coupled with a requirement under the act to have a residents' council as part of the accreditation, and a total quality management program mandating financial disclosure, all of which is in the Nursing Homes Act now, but then to add to that a similar provision that exists in the Public Hospitals Act now, where the minister has concern about quality of patient care progressive steps could be taken which ultimately would result in trusteeship. It's also permitted in the Nursing Home Act as it exists today. You would have that plus a more positive, continuous improvement model which would continue the existing compliance mode.

The big stick of trusteeship is a very heavy stick that's used very lightly because it is the ultimate, but it would remove, in my view, the financial penalty which would only—I think financial penalties are hurting the clients in those homes. What's your view on that kind of a model for ensuring quality improvement where you have a problem?

Mr Gibson: Again, it's the working relationship and the legislation is going to allow some appeal in the system. I guess everyone gets worried about getting locked in to a sort of situation and you're put in a corner. If there's a tool to not be locked in a corner, I think everyone can go along with it and I think the accreditation process will work very well. It's just that things won't work out if there isn't a means to back out of a situation or to justify a situation as well sort of thing.

An accreditation process works very well, contrary to what I've heard. It's a process I believe in—obviously having five three-year awards—and it is on an ongoing basis. Accreditation is not something that is here today or tomorrow. Again, it depends on the facility.

I didn't realize there would be so many of us here, so I didn't bring enough brochures of the facility, but for those of you who have a copy of it, that is something that has taken us a year and a half to do. The rose on the back of it, you'll see, is out of the garden; the hand is a resident. It depends on the facility you're going to be in and what type of home and how it's managed. It's the caring of the individuals. That whole brochure will tell you a lot, if you look very closely at it; the time it has taken. It starts with the administrator with a family. That particular family had five members in our home. Then it just rolls with the volunteers and there's a whole story in that. Again, it's what you're fortunate to live in and then the philosophies of the

facility, and to work with a system that you do the best you can, sort of thing.

Mr Cameron Jackson (Burlington South): Larry, thank you for your brief. I want to explore the concept of the difference in your operations, the nursing home versus the retirement, and how you have the flexibility to make up your losses in one given area. I think you used the word "subsidy." This is not too unfamiliar to some members of the committee, but I wonder how you see the new legislation correcting that, or will you be able to—are you protected, or is there still that ongoing expectation that you will be able to continue to have the one side subsidize the other side?

Mr Gibson: I guess what we're hoping will come out of the new legislation and equitable funding is that my nursing home portion would not continue to have losses, that the losses will stop, and then the return on the entire investment. The facility you're looking at is \$5 million. It's a lot of money. It's a lot of money for a small family and it has to have a certain return on investment. It has to have a contingency plan for the future, because the building is going to age. It's just nine years old now. With what we're losing, we're regressing with what we have today with the system, because my nursing home eats up \$112,000 of the profit or the contingency that you possibly would have. We would hope that would end.

Our rates: I guess we would not maybe have as many losses if I decided that—at \$58 a day, I'm one of the lowest retirement homes in the area but I also have more services. Most of our public institutions here in this city, in comparison, are \$68 a day for a room, and it's a shared washroom. You come to ours at \$58 a day and you have a four-piece suite that goes in the room.

It's a variance, again, as to how you have your losses, but then we know that the government is considering the retirement home industry maybe under the Ministry of Housing. There are people who have increased their rates drastically. But when we started nine years ago I was at \$32 a day and today I'm at \$58 a day, so in almost ten years I haven't quite doubled. But I can't just go tomorrow and be the same as a home for the aged in the area and go another \$10 a day, because we're already hearing from the representative before where they are objecting to the \$10 a day that's going to come out with extended care or the level-of-care increase.

It's an area that's really difficult, how to manage a facility and not be gouging the public, what is affordable to the public and give them the services they need. I guess we're hoping that this Bill 101 will make sure that we don't have any more losses and we have a return on our investment.

The other facility in Gananoque has 93 beds. Our profit there was \$35,000. Now, for a 93-bed nursing home, and you can multiple the equation at \$50,000 or \$60,000 a bed today, that's not a very good return on your investment and you wouldn't do it.

Some of you may know that we have a new facility in the Northbrook area that is opening April 1. We, as a family, were looking at that because we're Kingston, we have a lot of pride in our facilities and we give very good care. We want to do it in the Northbrook area but the dollars and cents are not there, and I don't know how that facility is going to work, even under the new funding, with the cost of a building that is costing today with these rates. It just won't work. So something that is nine years old or 15 years old, as with our facility, I can see it working, but not in today's.

Ms Jenny Carter (Peterborough): Thank you for your presentation. I'm sure the standard of care is very high in your facilities, but you did say that there are some facilities where you would not want to live and there were some where you would. You also suggest that the power of inspectors should not be increased.

We have various things in place or that are going to be in place to take care of this. For example, we talked about accreditation and we've heard differing opinions on that. Residents' councils: We discussed those that were presented to this group, and a lot of homes have them and they work very well, but you can't mandate those. You can't put them in legislation, so some places may not have them. We have the Advocacy Act coming in which is going to allow residents to phone a number and get help if they feel they are not being properly treated, and of course there will be a residents' plan of care.

But given that the residents must be central, does this cover the situation, or are we still going to see some facilities which are not up to standard so that we need more machinery in place to deal with this?

1140

Mr Gibson: I don't think we need any more machinery than we have today. The Nursing Homes Act is very sufficient. I think a lot of it is the implementation of the inspection area, the compliance end of it. Personally, I do not know why you can walk into a facility today and you can smell urine. Both our facilities are carpeted—you can well appreciate that carpet has not been changed in 15 years—and there are no odours. I do not understand when someone from the inspection branch, compliance, goes to a facility and there are odours.

I don't know. I guess it's just if the compliance officers can all think and tick the same and follow and implement the regulations as they should be, and if people comply to the recommendations at the ministry and that's all taken with sincerity. I don't know in our own industry why some facilities are that way, but there again, it's no different than the public sector either. You can go to homes in this area within a 60-mile radius and smell urine, and I don't know why.

I don't know how to answer your question. What we have is enough. You don't need anything more. It's how to make it work and I don't know those answers, because you can go—urine is a good one that we all know. That seems to be the big bugaboo and that seems to be where your nose tells you something when you walk in, where you're at with that facility, and why I don't know.

Ms Carter: So there's still something that needs to be done, but you couldn't suggest anything.

Mr Gibson: I don't know. I'm not in the inspection branch. Mr Quirt is sitting there. If he could go around himself and visit all the facilities, the whole 500 and some of them in the province, he'd probably do it himself, but you can't do that; you have to rely on other individuals.

It's the same within my own institution. There are things that happen that I don't like, and it's very difficult to stop some things sometimes because I can't be there all the time. I try. I have residents' councils. I had them before they were legislated, because I believe the residents have a right to have input within the facility, and they do every month. They meet on the second Tuesday. They tell me what they like and what they don't like. I answer it and I try to make it the best possible for them. I just wish all facilities possibly would work that way, but they don't.

The Acting Chair: Thank you very much. We appreciate you coming this morning and making your presentation.

Mr Gibson: Thank you for having me.

PROVIDENCE CONTINUING CARE CENTRE

The Acting Chair: The next group before us is Providence Continuing Care Centre, if those representatives could come forward and make themselves comfortable. I believe we have a copy of your brief, and identify yourselves, please, for Hansard. Help yourself to that good old Kingston water.

Sister Sheila Langton: Good morning, Madam Chairman, members of the committee, ladies and gentlemen. My name is Sister Sheila Langton. I am a Sister of Providence of St Vincent de Paul and senior vice-president of Providence Continuing Care Centre. Our presentation this morning, as you might imagine, is going to be a group presentation. Mr Guy Legros, our president and CEO, and Mr Wayne Westfall, a consumer of our services, will be speaking later.

We are pleased to have the opportunity to participate in the consultations on the proposed legislation associated with long-term care reform and redirection.

Let me give you some brief background information on our centre.

Providence Manor is a charitable home for the aged with 223 beds, of which 179 are classified as extended care and 44 are residential. Founded in 1861, the House of Providence was home to the Sisters who sheltered destitute elderly persons and orphans, cared for the sick in their homes and visited prisons.

In 1970, this home for the aged was renamed Providence Manor, and by 1991 a major building and renovation project was completed, allowing it to become a most functional gerontological centre.

In Kingston, the Sisters of Providence sponsor a 248-bed facility, St Mary's of the Lake Hospital, which has become a geriatric and rehabilitation centre of excellence for both inpatients and outpatients.

To maintain their tradition as leaders in continuing care, the Sisters of Providence and the governing boards formed the Providence Continuing Care Centre in 1991 to achieve a closer relationship in governance and management between Providence Manor and St Mary's of the Lake Hospital and to enhance quality of care. At the same

time, each long-term care facility retained its own mission and identity.

Quality care is provided through a complete range of specialized services available at Providence Manor and St Mary's of the Lake Hospital. The psychosocial, spiritual as well as clinical and physical needs of patients and residents are equally emphasized.

At the outset of our presentation, we would like to commend the government for its perseverance in redirecting our long-term care system. The transition to level-of-care funding is both sensible and long overdue. We support the government's initiative to address the inequities in resource allocation and accountability proposed in Bill 101. The public must be assured of continuous quality improvement and adherence to standard-based practice in the long-term care reform.

To influence the quality of care offered in the area of long-term care, the governing board and administration of Providence Continuing Care Centre would like to address the following areas noted in the proposed legislation: (1) coordinated access to facility services, (2) enhanced accountability in long-term care facilities, and (3) level-of-care funding for long-term care facilities.

Mr Legros will deliver this part of our presentation.

Mr Guy Legros: Coordinated access to facility services: As we understand it, admissions to each home will be made by a specific placement coordinator who will be charged with the responsibility of determining the eligibility of each applicant based on criteria which meet the level-of-care funding guidelines, will determine priority for admission to facilities and manage waiting lists.

The rights of individuals to choose preferred accommodation with their spouse or based on the ethnic population or religious affiliation of the home must be considered with other determining criteria. Bed accessibility cannot be the only driving force for placement; otherwise, people with stated preferences will be placed in available beds regardless of their choice. Failure to give due consideration to preference upfront will absolutely deny a quality of life that would otherwise be enjoyed.

In the proposed legislation, individual homes are also unable to exercise their freedom of choice with limited grounds for refusing a placement and no guaranteed appeal process. The rights of organizations are just as important as the right of choice guaranteed to individuals.

At the present time, we in the Kingston region enjoy an excellent working relationship with the local placement coordination service. We attribute this largely to the leadership style of the present management.

Providence Continuing Care Centre does support the placement coordinator concept. We recommend a continuing cooperative approach, assessing and matching facility resources with residents' needs using appropriate approval or review processes. Thus lifestyle choices which are crucial to human dignity and individuality would be maintained.

1150

Enhanced accountability in long-term care facilities: Bill 101 contains amendments which are designed to improve quality of care for the resident. It clearly distinguishes between what will and will not be allowed, with serious sanctions applied to deter non-compliance.

We support efforts to establish effective accountability mechanisms in long-term care facilities. However, we have concerns with the degree of external control that is being suggested in the legislation. We do not believe that excessive external rules and control will guarantee quality. There is an inherent difference between accountability and inspection.

The governing board of Providence Continuing Care Centre is composed of community representatives, serving without remuneration, who provide vision and direction to the organization to meet the changing needs of residents and their families and assure excellence. In addition, our governing board operates by institutional goals and objectives and ensures that services are delivered efficiently and economically.

At our centre, the governing board and administration have established a total quality management program, of which one goal is the creation of an empowered and enabled workforce with decision-making authority over day-to-day processes. In this way our health care professionals become more efficient and high expectations and standards are achieved through an evolutionary process from within.

We are concerned that the proposed legislation will not allow the governing board the flexibility to both meet changing needs and assure quality of care. We ask this committee to consider further amendments to retain autonomous governance structures with the flexibility to manage performance and change and to recognize the ultimate accountability of the board for the quality of care in each organization.

Presently, the area office of the long-term care division oversees our adherence to quality standards. Ministry personnel meet frequently with us and they are in touch with our consumers in the local community. When this is working very well, we question the need to change.

The concept of an external inspector should be rarely used and only in the most extreme circumstances, when it is clear to all that no other approach will suffice. We recommend that this portion of the legislation be accordingly revised.

Level-of-care funding for long-term care facilities: The amendments will establish the new level-of-care funding scheme. Service agreements will contractually articulate the services and programs which will be provided by each long-term care facility.

We suggest that this service agreement include a commitment to the funding level in order to fulfil the requirements of each service agreement. It is essential to equate care needs with funding. Bill 101 is silent regarding the government's goal to achieve needs-based funding.

In conclusion, we support the need for redirection in long-term care. This government's commitment to providing safe, efficient and effective health care is admirable. We ask that caution be observed in drafting legislation. Let us preserve all of the good aspects of our health care delivery system and continue to promote leadership and vision. We look forward to further participation and comment on the details of this proposed legislation.

At this point I would like to introduce to you Mr Wayne Westfall, who is a client in the attendant care outreach program sponsored by Providence Manor. I'd like to introduce to you Mr Wayne Westfall.

Mr Wayne Westfall: Thanks, Guy. I'd like to thank the committee for your interest in long-term care issues, and I'd also like to thank Sister Sheila and Guy for asking me to speak here.

I was injured climbing a mountain in 1979 and I've been a C5-6 quadriplegic since then, so I've had almost 14 years of personal experience with disability, and I've been a consumer of services in the community since 1980. I've seen a lot of changes since then, a lot of positive changes, and I hope Bill 101 will continue to further that process.

My professional background: I graduated from Toronto with a Master of Social Work in 1984 and worked both in the community and in institutions before my injury. I have worked in both since my injury as a social worker. Now I am a part-time teacher at St Lawrence College and at a local minimum-security institution. As well, I'm an aspiring artist, but we all know that you can't live on that aspect.

Mr Drummond White (Durham Centre): Keep your day job.

Mr Westfall: My day job, yes.

I'm speaking today as a receiver of services and also as a representative of sorts for those people like myself who live in a community but are unable to speak for themselves.

I just want to preface my remarks with a couple of comments. The converging realities of increasing health care costs, decreasing money available and an increasing number of people needing services is really forcing difficult changes. We're all very aware of that. In the past couple of years it's been extremely severe, and I don't see how that's going to change.

In my own opinion, in order for us to effectively meet what is a crisis and is going to get worse in terms of health care, it's essential that we encourage and we demand consumer responsibility for their own health in the community. I think in order to do that we have to provide structures for people like myself to live in the community and to live decently. That's why I'm here today, to talk to that. My comments—I never get the chance to speak to your standing committees, so some of it may relate to Bill 101 and others are just going to relate to my own agenda, which I could fit in there somewhere if I needed to.

First of all, I want to talk about direct funding, which is the issue directly related to Bill 101. I think direct funding is a good idea, and there are certainly some people with disabilities who will take advantage of it. By and large, though, I don't think it's going to be used by very many of us because it's too complex. If, in addition to my life as it is now—working, organizing my life—I had to structure wages and benefit packages into my attendant care, I wouldn't work: it would just be too complex. And I believe that's the case for most people like myself.

However, my situation—and I'll talk about it in more detail later—provides a maximum flexibility which allows

me, basically, to hire my own attendants and to leave the paperwork to another organization that is better suited for that function

The big advantage, though, of direct funding, where the money goes right to the client, is that it offers portability, and at present there is no portability of services, of funding. If I leave the services in Kingston and I move out of this catchment area, the money stays behind with the outreach program. Basically, that means I don't move, because there's a waiting list everywhere; I'd be years trying to get somewhere else. So my opportunities to move are extremely limited, the same as anybody trying to move to this place. It's impossible with the current structure the way it is.

1200

I think that does a number of things. Besides limiting my movement around the province, my opportunities, it taxes specialized services in the community such as access, transportation, because people have to come to Kingston for rehab services; they can't go back to their local communities. Transportation services get taxed, accessible housing becomes taxed. Also, employment possibilities: All of these things are really limited. Because basically, what we do is we ghettoize people with disabilities. Kingston ends up with a whole bunch of people, and the rest of Frontenac county has almost nobody, because this is where you have to live in order to get the services you need.

I think another result of that is we end up stereotyping people with disabilities, partly because we just put too many of us in one area, the same as any ghetto occurs when too many people who are a minority live in an area; there's an inevitable opinion that forms in people's minds about individuals. That's a fact of our reality, and that occurs in Kingston also.

Now, the purpose of the outreach program, which I get services from, as I see it, is to maximize the independence of consumers like myself to live in the community and to do this at a minimum cost to the taxpayer. I'll give you an example. In my case, it costs the government about \$300 a week to keep me in the community. For that, I hire about six to eight people at any given time around my payroll to provide the services I need. This program—it didn't start till, I think it was 1985.

Before that, since I was a social worker and to get out of hospital in 1980 there was no program basically, I wrote up my own program. I funded it through voc rehab, which I knew funded employment opportunities then. So I said: "I've got to get a job but I need an attendant to get me to the job. Can you fund me?" It was flexible, and they funded me. That's how I stayed on the program for about four years, until the outreach program came into existence, and none of us had to play these games any more.

But I've been working since 1981. I pay taxes, I live in my own house, I don't live in subsidized housing. I pay for all of my drugs because there's no drug program which thinks I'm a safe enough bet to live long enough to warrant their expenditure. I was on Blue Cross. I went off it for a while and tried to get back on, and they said, "Sorry, we don't want you any more." I also pay for all my medical supplies. The only thing that ADP, the assistive devices

program, covers me for is a wheelchair, and that's once every five years. Everything else, and that's about \$2,000 a year, comes out of my own money.

None of that would be possible if there weren't a community support program such as outreach. Basically I'd be living in an institution. The institution I'd be living in in this community, because of the level of care I need, would be St Mary's hospital, and the cost there—the figure I was given—would be about \$6,900 a month, to keep me at St Mary's in one of their beds.

So figure it out: I cost about \$15,000 a year to live in the community and do the things I do versus almost \$7,000 a month to live at St Mary's. Within three months at St Mary's, you've already paid for me to live in the community for a year. So in terms of outreach and whether it's cost-effective or not, I have absolutely no question that it is.

A bit more about the outreach: The program here, we have a budget of about \$800,000. It serves 58 people and it employs 75 staff, some full-time and some part-time. Again, you can do a little mathematics: 58 people, \$800,000, that's about \$14,000 a year to keep us in the community—not very much money—as opposed to that same budget, \$800,000, a dozen of us at St Mary's and we've eaten it all up. So I think there's a huge benefit in having structures like the outreach program available.

Kaye Faust, who's a coordinator of the program, tells me that a half to three quarters of the people on the program would require institutional care of some sort, that we would not be able to live in the community if we did not get attendant care. Maybe not all St Mary's, but we'd all have to live in structures, in institutions.

Another thing is that it's great job creation. I employ a lot of people. Most of the people I employ are minorities themselves. Some of them have mental disabilities, some of them are immigrants, some of them are students, a lot of them are either unemployed long-term or they're newly unemployed. So a lot of these people have their own difficulties which prevent them from working in the larger workforce.

The way the program is structured is that Providence Manor—this is one of those rare cases where a community program is run out of the institution and actually works—has two coordinators. They basically take in applicants who want to work on the program. But then, people on the program have any number of levels of responsibility, so somebody like me—I phone up Kaye, she gives me names, I contact the people or they contact me, I interview them, I select them, I train them, I schedule them and I hire them, if necessary, and I leave the paperwork with the outreach program. They do all the CPP and the UI benefits and all that stuff. If I didn't want that responsibility or I wasn't able to take that responsibility, then the coordinators of the program would take that. That can operate at any level in there.

The Acting Chair: Excuse me. I really don't want to break in, because personal experiences are so beneficial to this committee, but I know there are people who will want to ask questions. I've already had several hands up. If you could just summarize, because we are coming to the end of

the allotted time and we have to begin again right sharp at 1:30. I hate to do this to you, because it's very valuable, what you are providing this committee.

Mr Westfall: I'll tell you why I think the outreach program works. First of all, it is run out of an institution that does care for people, but mostly the advisory committee is made up of professionals and two consumers—I'm one of them. It's a non-hierarchical committee where everybody has equal input—I don't have to call the doctor "doctor." There are two first-class coordinators who really care about the people on the program. They know us all individually and they know how to respond to our situations individually.

We bend the rules to fit the clients on the program rather than the reverse. That is inevitable; you have to do that in order for anything like this to work. No amount of regulation is going to ensure that all my needs are met, and met on a humane basis.

The wages are good, from \$11 to \$13 an hour, which is what a person providing the same work at Providence Manor would make. That gives me reliable attendants with continuity and consistency. I wouldn't get that through a private agency. You would pay them more to pay their workers less to come and work for me. People quit on \$7 an hour: they'll stay for \$11 or \$12 an hour.

Every two weeks, I'm given a certain block of hours and I schedule those hours to do what I need when I need with the person: one hour today, if I need it, and seven hours tomorrow, if I need it. As long as I stay within my limit, it's there. So huge flexibility.

My scenario, if I had a choice, would be that when somebody moves into the community or they're in the community and they need a level of service, we calculate—whoever "we" are—how many hours this person needs. We give them a dollar figure based on that number of hours and then allow them to do what they want with that money, to hire who they want and to hire those services through who they want.

That way I can move out of the community if I wish, I can hire an individual if I wish, I can get my services through an organization if I wish and I think in that way it ensures good quality and it also ensures competitive quality. If I don't like what Providence Manor does, I'll go somewhere else and I'll be the judge of where I go and what quality is.

In terms of accountability, I think there are lots of ways for checking that, but when we give people money for mother's allowance, disability pensions, unemployment insurance, Canada pension, who checks that for accountability? That isn't checked, so I don't see that that should be a major stumbling block in this case either.

1210

My suggestion is that we keep the service agencies small. Kingston at some point is going into an integrated homemaker program, so attendant care services are going to be available on a broader basis. My fear is it's going to move into one organization, probably the local health unit, which is going to have another level of bureaucracy servicing huge numbers of people, and that we're not going to be

able to respond to the individual situations on a quick basis and meet the needs which—somebody follow me around for an hour, for two hours and see the kinds of needs I have. They're very individual. They can't be met under a bunch of rules. If it gets into one organization servicing hundreds of people, that's what's going to happen.

If you want to increase options and you want to do that with a high quality of care, then I think we need to have smaller organizations working within the same community and giving consumers like myself opportunity, choice and responsibility. I have a lot more to say, but that's enough.

The Acting Chair: Thank you very, very much. I'll move directly to Mr Jackson.

Mr Jackson: Wayne, thank you for the insights to the program and to your personal experience. They're helpful. I was rather shocked, years ago, when I learned about the relationship between workers' compensation and direct funding arrangements. Could you clear up for me—are you liable for the workers' comp? Does it flow from you as the employer in this program or does it flow to the program generally?

Mr Westfall: Since the program has run out of Providence Manor, it is liable for the workers' comp.

Mr Jackson: So this goes on Providence Manor's WCB rating.

Mr Westfall: Whereas if it was direct funding, then I'd have to do something about that myself.

Mr Jackson: Yes, under direct funding it's my understanding that you would. That was the point you were underscoring about the excessive amount of paperwork and the filings. I have constituents who have gone through a nightmare with workers' comp, where what the government pays for the service is almost being lapped by what the WCB charges. It's incredibly—

Mr Westfall: The way the program is structured now, for me it's ideal, because I do everything. I have total independence in my life in terms of my attendant care, but I don't have to do any of the paperwork.

Mr Jackson: I understand that, and most of us who have the opportunity to work with the differently abled community and our constituents have had—it's hard to understand that we might have a glimpse of the experience, but some of us have had the opportunity to do that. It was this accountability shift which you touched on that I wanted to explore a little more deeply. Perhaps the representatives of Providence Manor may wish to comment about this issue of liability, and then I'll pass to the next questioner in the interests of time.

Mr Legros: I'm not sure I can address that. I think the staff, as outlined by Wayne, are funded by the Ministry of Community and Social Services, but they are part of our payroll and the liability coverage etc is covered and we have insurance, and also the workers' compensation package etc.

I think one comment I should perhaps add is that staff are not professionals per se; they're not social workers or therapists or whatever, but they are our staff and live our mission. Mr Jackson: Thank you.

Mr Paul Wessenger (Simcoe Centre): Thank you very much for both your presentations. I feel that we needed really enough time for each of you individually, because we've got two points of view here which I very much appreciate, and particularly yours, Wayne, with respect to your personal perspective.

First of all just dealing with some of the concerns about consumer choice and inspection, I'd just like to assure you that the place of coordinating an agency will continue in this area as it now basically does and the consumer choice is very much an essential part of that and will continue to be part of that, and we're certainly looking at seeing there are some assurances we can give in a visual way, because that's certainly the intention.

With respect to the inspection process, I'd just like to also confirm that the same people who are doing the inspection will continue—the advisers will continue in that role, and there are no plans at all that would in any way change the process. It's just going to be a merging of the two divisions, the nursing home and the home for the aged.

I'd like to just ask one question of Wayne with respect to this delivery of service. You indicated you had a preference for a multiplicity of service delivery as distinct from one organization delivering it. Would that mean that in a sense, as we move—I don't know whether you're familiar with moving towards the multiservice agency concept—I would think you would probably be in favour of a more devolved model of multiservice agency where the agencies have an overriding devolved model where they work in a cooperate, integrated manner, but still preserving their individuality.

Mr Westfall: Well, I realize there's duplication of services and a lot of that duplication isn't necessary. I've been around a long time on both sides of the fence, so I've seen it and I know some of the complexities. But there are situations where duplication of service is useful. I think there are going to be a lot more people who are not as disabled as me but with all levels of disability living in the community and going to need help.

So in Kingston we're going to have hundreds of people needing services. To me, having a variety of agencies running that is fair enough, because I think what happens with institutions is that when they get too big, they lose that humanity. They have to. You can't serve a thousand people—the coordinator can't know everybody. If they service a hundred people, they can. So to me, the best way is to keep it small, which I don't think is inefficient either, because the kinds of things that keep me in the community can be dealt with if a person knows me personally. If they don't, I may have to go to a hospital. What if I go there for a week? The amount of money that costs—a few of those can easily pay for a coordinator's salary for a smaller program. Do you understand what I'm saying?

Mr Wessenger: Yes, I do. Thank you very much.

Mr Randy R. Hope (Chatham-Kent): I just have a quick question. I'm going to go fishing here because I notice that in your presentation you talked about levels of funding, and I wanted to bring in the perspective of the

copayment or user fee—I'll use the terminology; it's been used in the committee.

What do you see as that, and I'm wondering—just for your views on the fee structure for residents, because you live in a rural area. I'm sure there are people who still want to live in their home. A spouse might want to live in the home, but because of circumstances, somebody has to move to the residence, and I'm just wondering your viewpoint on that.

Mr Legros: Well. I think that the fee structure as it exists has been working. I think there are proposed changes, for instance, that we would be looking at income versus assets and so on, to arrive at the amount monthly that would be paid by the resident, and whether he or she can afford to pay etc. I guess what I might say is that we do leave \$112 per month as a comfort allowance to each resident, and obviously, the \$112 per month is eroding for a variety of reasons, I guess not just inflation etc, but with the current changes to the Ontario Drug Benefit Act, for instance, many items that were previously absorbed by the ministry, the government, for the over-65s now must be paid by the resident, and the only source of funds they have is from that \$112, and that's a new problem that exists. I think that the user-pay philosophy is not a popular one because people, if they can, will let the state pay as much as the state will absorb and they'll do whatever they can to keep it down. This is not true for everyone, but a lot of people would take that approach. I'm not sure if I'm answering your question.

1220

Mr Hope: Like I said, I was just going fishing for your comments about the copayment aspect and looking at the individual, and I know you deal with individuals.

Mr Legros: The biggest problem with copayment as it exists now, for instance, in the hospital sector is the fact that it doesn't start until after 60 days. I think that's something that needs to be looked at. I think that several governments have looked at that, but there's been no change. I think that that should be changed because if you get in a taxicab the meter starts right away. So because we are under tremendous financial constraints, we need to look at that as a feature.

The Acting Chair: Ms O'Neill, I'll go to you, and then if there is time at the end, we'll go back over here.

Mrs Yvonne O'Neill (Ottawa-Rideau): Thank you, Sister Sheila and Mr Legros. I think you brought forward to us many of your concerns about the placement, governance, needs-based funding and the enforcement mechanisms and the sanctions that accompany those. I just have one question for you and one for Wayne. Do you ever have to or do you accept people on emergency call now for placement? How does that work in Kingston with the coordination placement?

Sister Langton: As we said, we feel that we have such a tremendous working relationship with the placement coordination service that indeed it is handled according to our mission. We look at individual cases. Yes, we do have a waiting list, but there are times when people cannot wait. It has been our tradition in Kingston—we've been here

since 1861, remember, and we've served the needs as we saw them and we have luckily been able to continue that with placement coordination because of the flexibility at the top. If that approach could continue, then we'd be very happy. But yes, we do handle emergencies.

Mrs O'Neill: Mr Wessenger has been saying that he's going to beef that section up some way, or at least ask the minister to, so I hope we can, because you're not the only person who has some concerns about that area of the bill.

Wayne, it has been very helpful for you to give us your perspective. I think some of the best witnessing we have has been from residents' councils and from people like yourself. You told us a lot about the way you manage your life and it certainly seems to be going quite well.

You did, however, express some caution at the very beginning of your remarks about the direct funding that is going to be very much part of this bill. Would you say a little bit more about why you have cautions about that and how you think, either for good or bad, this is going to be played out for the disabled community?

Mr Westfall: If the direct funding is only going to be open for individuals who want to hire the services, I don't think many people are going to use it because of the complexity of all the other things. If I, for instance, got direct funding, I'd just turn around and hire Providence Manor so I wouldn't have to do all that stuff. I have enough in my life without being an employer with the paperwork as well.

Mrs O'Neill: You're the first person who's brought that perspective to us so it's rather interesting that you would state that. I think there will be some difficulties that maybe are unforeseen at the moment.

Mr Westfall: I think that should be an option that's available for people. I know some people with disabilities who are very keen on it, which is great, but I think most of us, we just have enough other things to do that—

Mrs O'Neill: Perhaps we can put something into an amendment that would attend to that.

Mr Westfall: My point really is, when I say, "Give me the dollars and then let me hire who I want," would in my case be, "Give me the dollars and let me hire an agency that is going to do all that paperwork." But I still have the opportunity of saying to the agency whether or not I like the kinds of services I'm getting through them, and if I don't like those services, I could take my dollars, move them somewhere else, to get the kinds of services that I feel I need.

Mr Wessenger: Could I just perhaps clarify that direct funding is an option, not a requirement.

Mr Jackson: Not even a reality yet, let alone an option. It's not even in distinct language in the bill that it's going to happen.

The Acting Chair: Keeping in mind that it's one hour and we have to be back here.

Mrs O'Neill: Could we just have—since Mr Wessenger did throw that statement out, is there also the second caveat then that a situation like Wayne expresses regarding

hiring an agency would be acceptable or does it have to go directly to the individual?

Mr Wessenger: The model has not been developed, but to me it would make sense that one would have the option of going to whatever organization or person who meets whatever the qualifications are to obtain the services.

Mrs O'Neill: Well, you'll be quoted.

The Acting Chair: As I said before, keeping in mind that we do have one hour and then we'll be right back here at 1:30 sharp, and I say that directly—briefly.

Mr White: Thank you. Wayne, I was very impressed with your statement, with your testimony. The issue I wanted to pick up on, because of the briefness I'm being pressed into, was in regard to the committee that you referred to, and I'm thinking in terms of the instruction really necessary for the placement coordination services, for the direction of services to people who are physically challenged or the elderly.

We've heard a lot about people who are going to be hard to place. We've heard a lot about medical needs etc, and I'm wondering from your standpoint whether you don't think that it's important to have a voice that speaks for the individuals, for the families, from a professional standpoint, from a psychosocial standpoint, a voice that speaks to their living circumstances.

Mr Westfall: Yes. You're talking about the advisory committee for the outreach program, and on that we do have the requisite number of professionals, in terms of physicians, occupational therapy, nursing, administrators, and there are two consumers and also the coordinators of the program who know the individuals. They know them

all personally. They're right in their homes. So they really do know these people and I think we cover all of that ground and that's the total—

Mr White: You do. Actually, I was thinking also of the placement coordination services with their advisory committee. Do you not think that there should be a voice there, such as you have on your advisory committee, for a psychosocial voice, for a social worker or someone else who could speak to the family and the needs of that particular person from a psychosocial perspective?

Mr Westfall: You mean in terms of placement coordination from institutions into the community and vice versa?

Mr White: Yes.

Mr Westfall: I think we have to involve people who have the situation themselves as much as possible in all of these processes. To me, it's the only way to go.

Mr White: Absolutely. Thank you very much.

The Acting Chair: Thank you very much. I thank you for coming and for bringing your perspective and hope that all of these things that you have heard people say will assure you that we will get some amendments to this bill and maybe we can really work towards the continuum of care that we want, and you can provide the good service that you have since 18—

Sister Langton: Sixty-one.

The Acting Chair: Eighteen sixty-one, and I remember it when it was the House of Providence very well. Thank you very much for coming. Thanks everyone, and we will resume at 1:30 sharp.

The committee recessed at 1230.

AFTERNOON SITTING

The committee resumed at 1334.

The Acting Chair: If I could have people take their seats, please, and the committee members please come to their places. We do have a full afternoon agenda here, and I'd like to be able to have as many questions as possible. Ms Carter, are the other members of your party available? Here's one, okay.

Good afternoon, ladies and gentlemen, and welcome to the standing committee on social development, dealing with Bill 101, An Act to amend certain Acts concerning Long Term Care.

COUNTY OF HASTINGS. HOMES FOR THE AGED COMMITTEE

The Acting Chair: I would ask the County of Hastings, Homes for the Aged Committee representative to come forward. I'm Joan Fawcett, the acting Chair this afternoon for our usual Chair, Charles Beer. Welcome gentlemen, and if you would identify yourselves for Hansard, and then begin your presentation.

Mr Lloyd Churchill: Thank you, Madam Chairman. I'm Lloyd Churchill, homes committee chairman for Hastings county, I'm also a member of county council. With me is Rob McLaughlin, our homes administrator in our Bancroft home.

I thank you for the opportunity to able to appear before you today. Rob is here as my counsel because I'm sure that Rob, in his very competent position as administrator of our home, is a lot more adept at answering the questions that may be posed than I myself. Yet, I think that I have had a learning experience today, looking at it as not one involved with social programs or with the administration and carrying out of those programs, but more or less with an independent businessman's view of how operations work.

Probably I'm in an fortunate or unfortunate position, whichever way you want to look at it. I have a great interest in senior citizens, what's happening to our homes. I've been on the committee for four years, the last couple of years chairing that committee. I think that we have two good homes that are well run, well administered. But as an outsider, I look at what is happening in our long-term care, the government programs which are being looked at, and I applaud the government for the direction in which it is going and what it is looking at.

I also have grave reservations. I have worked as an independent businessman for 20-odd years and have been in a position for 14 years in corporate business and 20-odd years of my own business, and I have been in the position, good or bad, to make decisions when they had to be made and get on with running a business. I think if I had taken the time to make some of those decisions that I see the government having to take to make decisions, I would have been wiped out by my competition years ago. This is no slight on the members of this panel, because I realize that you represent different parties, and certainly the implications of what we're looking at today were not all imposed by the party of the day.

Sometimes I very much question the time that we have our homes administrators spending on budgets and preparing budgets in the field of uncertainty in which they work. Once again, private business could not operate that way. I see ourselves operating and preparing 1993 budgets when, at the same time, we don't have approval for 1992 budgets. I don't think we can recapture those expenditures from 1992. They're gone. They're spent. Thank you for giving me the prerogative of doing that; it isn't in my submission, but I'm usually known as saying what I think. My wife says that's not always good.

But I think probably all of us, and certainly the members of our government today, see the writing on the wall. I think sometimes we fail to see that the writing on the wall is addressed to us. I also think the government is trying to put the train back on the track. Perhaps they've got it back on the track with the direction in which they're moving, but I question which way the rails run.

With those opening, probably uncalled-for, remarks, but my customary remarks, I see total frustration in having to deal with the ministry with which we are dealing in our homes, when we are still wondering and asking and looking for questions, which I ask my administrators. "What is the direction?" I've been asking you for two years, "What is the direction in which we're going?" And they're still unknown questions today what that direction is going to be.

So hopefully with the submissions that you hear, with your travelling around the province at this time, having these hearings—and I'm sure that they must get very boring for some of you members, because what you hear and what I've heard today is pretty well the same line, the same content in all the directives, that the same questions are being asked.

The Acting Chair: Usually there's something a little different.

Mr Churchill: Yes, that's right. Hopefully, there will be in ours, Madam.

Mr Owens: It's already started.

Mr Churchill: I also appreciate the fact that the three people who are here today I found very informative. I almost see myself as an outsider as a provider of care. I don't become involved in those things. You people who are involved and certainly our administration in carrying out those programs are some very dedicated people. I think we have some very dedicated people carrying out the mandate of the health services department of the government in a very confused and unsure position of where they are and where they're going. I find it must be total frustration for those people having to try to cope and carry out those policies.

1340

Getting back, I do appreciate the fact that we can come here today—

The Acting Chair: Don't apologize for your remarks, sir, because if we are going to make this system better it never burts to start with the truth, and we need to hear that.

Mr Churchill: Thank you and I appreciate that. So I guess the truth would be, hopefully after today and the completion of your committees and the hearings that you're holding across the province, somewhere in the not-too-distant future we can see something but words and some action. To my thinking and the way I've looked at it a number of years, I have heard lots of words but little action.

The Acting Chair: Point well taken.

Mr Churchill: By the way, I have him here as my solicitor to answer any questions that you may put his way, and he carries the brunt of the load. I said he should be giving this deliberation rather than I. Thank you for your indulgence.

I wish to thank this committee for the opportunity to express the following comments, questions and concerns that Hastings county has with respect to Bill 101:

With respect to social services improvements or changes under Bill 101, our homes board of management finds itself in agreement with many of the objectives of the present government. At the same time, we would stress retention of the more positive aspects of the present system which have served our community well. Of course, changing times advocate policy renewal. However, it is our concern that new policy, built on past experience, would remain flexible enough to satisfy the concerns of those for whom it was originally implemented.

As background information, Hastings county has for many years attempted to be responsive to the needs of our aging population. In 1951 Hastings Manor was opened to replace the outdated House of Refuge. Subsequently, expansion to the original facility was undertaken. As a result of this expansion, additional beds provided were for residents in need of considerable hands-on nursing care.

In 1984-86 we renovated Hastings Manor to upgrade the accommodation and service to the residents. In 1967 the county of Hastings constructed a second home for the aged in the town of Bancroft. Its purpose was to facilitate the elderly who were in need of residential, nursing and medical care.

Hastings Manor has a licensed capacity for 256 beds, of which 198 beds are allocated as extended care and the balance of 58 beds as residential care. At Hastings Centennial Manor, the licensed capacity is 104 beds, of which 66 beds are allocated extended care and the balance of 38 beds as residential care.

When the previous government announced its intention to introduce a new redirection for long-term care, we knew that it would have a significant impact on the services and levels of care that we would be expected to provide. However, if homes for the aged are to admit fewer residents who need minimal nursing assistance, what facilities and services would be available in the community for them, and how will these community services be funded?

It is approximately two years since the redirection of long-term care was announced, and we still have very little detail on the whole process. We do know that residents of

our facilities were classified last September 1992 as to the level of care they required. We know that we will be expected to meet specific standards in all aspects of the facilities' operations. We know that the funding formula will change. We know that we will be expected to sign a service contract requiring us to meet certain standards in return for funding. We know that we will have compliance officers inspect our facilities. However, no detail has yet been provided on any of these items.

We, as a municipal government, agree that the principles of the provincial government regarding redirection of long-term care are needed. It is indeed time to address the misinformation and confusion that exists, not only from the general public but service providers and community service agencies.

All levels of government must deal with increased costs in the delivery of services, and all share the concern of how to pay for these same services. Provision of health care services to our aging population is a high priority to all of us. We are receptive to the government's efforts to improve service to the elderly and its stated intent to assist in the costs related to nursing services, programs and facility operations.

Hastings county does have some concerns with Bill 101 as it is now proposed, and a few are the following examples:

Admission process: Under Bill 101, all admissions will be processed through a placement coordinator. This placement coordinator will determine eligibility for admission and priority of admission. The facilities we own and operate will only be able to admit applicants deemed appropriate by the placement coordinator. At present, the admission process, as legislated, can be a lengthy process and does need revision.

Currently, the medical documentation required from the physician takes an average of three to four weeks to obtain. In addition, it usually takes one to two weeks to arrange an appointment that is convenient with the applicant and/or family to complete the required forms.

While we see merit in the gathering of information by a central agency, it remains to be seen if the medical documentation required can be obtained from the physicians in a shorter time frame by a placement coordinator. If we are aware that the applicant is in hospital, the discharge planners are very helpful in having the medical documentation completed in a shorter time frame. It must be emphasized that not all the applicants are in hospital and we do not see how the placement coordinator will be more effective than we are in obtaining the required documentation for applicants in the community.

How will information be obtained from applicants in the community? We trust that any changes to the collection of data for admission criteria do not encourage duplication of service or costs.

Right of choice by applicants for admission to a facility: The vast majority of admissions at both of our facilities chose these locations through personal or family choice. Needless to say, both our homes enjoy a good reputation within their respective communities. Virtually all of our applicants have lived their lives within Hastings county and relate to our facilities through family, friends and familiar surroundings. We would not want to see this changed.

Over the years, their tax dollars have helped support our homes, and from this they have developed a sense of ownership in their homes for the aged.

It is not an unusual occurrence that some applications are completed in advance and we are requested by the applicant that it be kept on file until he or she is ready for admission. These are usually the frail elderly who are competent but wish to remain in their own homes as long as possible. We would wish for this possibility to continue.

Our residential beds are always full. For those applicants who freely choose to be admitted, they should have the right to choose a facility they know. Will these people have this right of choice through the placement coordinator? It is very important that this be known at this time, especially when our two homes are some distance apart in location.

Funding: Under our current funding subsidy the Ministry of Community and Social Services, after revenue by residents, cofunds the facility for 70% of expenditures up to the provincially established cap. The municipality's share of expenditures equates to 30% of the cost after all revenue and 100% of all expenditures exceeding the cap. We are advised by the ministry that if our nursing and medical documentation supports the level of care delivered, the province will totally fund that service. We are advised that programs for residents will be fully funded.

We are advised that a set fee of approximately \$37 per day will be established for the residents to pay for accommodation costs. This fee would be for those residents who are not in receipt of the guaranteed income supplement. Residents who do not receive GIS would be charged on a sliding scare and the province will fund the difference.

This funding method does not take into account the assets a person may have while having their accommodation charges subsidized. This does not seem equitable and could possibly result in an additional burden on the taxpayer.

All of our future admissions will be at the discretion of the placement coordinator. Those admissions will be only those in need of the ever-increasing levels of care.

In recent years the financial contribution by the provincial government for long-term care facilities has not kept pace with the increasing demand. Do we have any assurance that the funding under Bill 101 will keep pace with the increased service requirements?

We are presently setting our county budget for 1993. Our home administrators have been advised by ministry officials to prepare their budgets, as they have in prior years, and that no facility will receive less funding than in 1992. Hopefully, given that we are still waiting for ministry approval for our 1992 budget, it is not indicative of the level of competency with which future process will be carried out. Is this a signal that there will be a decline in future provincial support for long-term care? Perhaps an amending formula is needed to link the commitment to quality with provincial funding.

There are many questions to be answered with regard to funding and we anxiously await ministry input or seminars on this topic.

1350

Accountability: Hastings County, as the owner of two non-profit homes for the aged, understands and accepts its responsibility to provide for the services needed by seniors. Our homes for the aged committee are elected members of county council and therefore have close ties to the communities our homes serve. This committee meets regularly, with the homes' administrators in attendance. Our administrators report to the committee on topics such as exceptions in day-to-day operations, expenditures not anticipated and recommendations to improve or enhance our services.

In our opinion, accountability to the community exists now. Perhaps in the large urban centres, the close ties to the community through the elected officials and the homes' administrators is less evident than in our more rural locale.

Quality assurance: We agree that there must be some method of measurement of the service being provided by all long-term institutions. It is our understanding that standards are being developed for all aspects of the operation of the facilities. When we have these standards shared with us, we trust that any comments or recommendations will be heard and given consideration.

A point of concern for our board is the possibility that Bill 101 incorrectly assumes that the provincial inspection process of facilities will automatically increase the quality of service.

We must utilize caution in creating a further bureaucratic hierarchy. At the local level, would we not be distancing ourselves even further from the voices of those to whom we are responsible? If we, the owners, are accountable to the government by means of the service contract for funding required, does it not follow then that, as owners, we will ensure that our non-profit facilities meet these standards?

With the principle of accountability accepted by Hastings county, we question in the strongest terms the need for compliance officers. We see the introduction of these compliance officers as an added level of bureaucracy which is not needed for non-profit facilities. Surely, the tax dollars needed for the inspection process proposed could be better used in funding of direct care and services to seniors.

In conclusion, I would like to again emphasize Hastings county's position, which is that we agree with the stated principles of the provincial government with regard to redirection of long-term care. It is our hope that with the best of intentions, the provincial government does not discount the positive aspects of the current system. The right of our seniors to choose for themselves to remain in their homes must be acknowledged. When this is no longer a viable situation, they must also be allowed to select a long-term care facility they know and are comfortable with.

As the owners and operators of non-profit long-term care facilities, we will continue to provide quality services and commit to provide excellence in service delivery. We do wish to stress that cost related to the introduction of compliance officers for non-profit facilities must be identified as part of the overall costs of redirection.

We do have concerns for the adequacy of the proposed funding for facilities and community services. However, we must wait until the actual funding process is announced before judgement can be made. We fully expect an opportunity for consultation.

Again, I thank this committee for the opportunity to put forth the views of Hastings county regarding Bill 101.

The Acting Chair: Thank you for coming before this committee to give us your views. I'll begin the questioning with Mrs O'Neill.

Mrs O'Neill: Thank you very much. I'm glad your brief ended with the request or expectation almost that we would have further consultation on issues such as funding, which is really very, very nebulous in Bill 101. Many people have brought that to us, particularly with what seems to be a much more centralized system. The placement coordinator's role in that and the level of care sometimes seems to be laid on the facilities rather than part of the facility's program.

Mr Churchill: I have faith in your government that it will do it.

Mrs O'Neill: I'm not a member of the government, but I am a member of the Legislature.

Mr Churchill: Is there a difference?

Mrs O'Neill: Sometimes.

Mr Owens: Yvonne had her chance

Mrs O'Neill: Maybe not fully. The bureaucracy and the buildup of bureaucracy that seems to be part of Bill 101 also seems to be part of your caution. I think it needs to be noted as well.

There's one part of your brief that is somewhat different—a couple of parts—but I just wanted to have you go back to page 6. There are two things I'd like you to expand on a little bit. You're the first one who has at least brought to our attention—maybe the only one who's been honest enough—that you have applications in advance from people who are not yet ready to move and that these are now honoured by your home. Could you say a little bit more about how that fits in with a waiting list that would be normally considered, having a component of care need.

Mr Churchill: We do have applications on hand at all times in both of our homes. Our board, of which I am a part, the board of management of those homes, usually relies on the competence of our administrators to bring those applications forward. Quite often, you'll have people residential in our village, in our communities, who think somewhere down the road they may possibly enter our home. So they have everything prepared and hopefully can move forward when that time comes. It's usually been the practice that when those applications are probably brought on stream, the administrators bring it to our attention, and they give their evaluation of that process or of that applicant, where he stands in regard to the criteria of family being able to look after him, what his independence is and how bad his needs are.

Mrs O'Neill: Would you do that on an annual basis when you do those?

Mr Churchill: Monthly. We have a monthly list and that's discussed at every monthly board meeting.

Mrs O'Neill: That's very interesting. As I say, you're the first one, I think, who's brought that forward, and it certainly ties in very closely with the community-based care aspect of this bill.

Mr Churchill: I think it's very different, if I may call you Yvonne. The fact is our homes are in smaller areas where we are more conversant with the people and the applicants who are requiring to come into our homes. Most of the time, we know them on a name-to-name basis.

Mrs O'Neill: Which I think is something we have to note. Could you say a little bit on your other concern regarding, if we want to call it as it was this morning, the user fee now being somewhat based on income and not considering assets. You are a business person and I think I'd like to hear you say a little bit more about that part of your brief.

Mr Churchill: I think we have to acknowledge that in this society in which we live today, there's no free lunch, and everybody is entitled to pay their way or should be entitled or expected or requested or feel it important that they pay their way.

If we go into this capping process which the government is alluding to, I believe there are many residents who will end up in our homes who do have some ability to pay, and this will change from home to home. For instance, in the two homes we have now that we administer in Belleville and Bancroft, there is a different level of ability of those people to pay. It's brought about I think by the little bit more affluent families we are serving in the Belleville area compared to the less affluent families we are serving in the north area.

We think, as a board, if that person has the ability to pay, then he or she should pay more than those who do not have the ability to pay. I believe by putting a cap on that, you're putting everybody on the same level. Inadvertently, that is going to be picked up by the taxpayer. In all due respect, we are sometimes paying, as taxpayers, for something which that patient or resident could afford to pay themselves and probably would quite gladly do so in some cases. Not everybody is out there looking for a freebie.

Mrs O'Neill: You and others have brought that to our attention. I think it's something we should really look at.

1400

Mr Noble Villeneuve (S-D-G & East Grenville): Thank you for a very succinct brief. Rural Ontario shoots from the shoulder, and sir, you shoot from the shoulder. That's kind of nice to hear. It's also nice to hear your comments that, more so in rural Ontario possibly than in urban Ontario, would people be willing to pay their fair share. You'll notice it in many instances, and I think you've touched on it to a degree.

The mix of residents in your two homes: Would they be 50% from your more or less urban areas and 50% from strictly rural, or what's the breakdown?

Mr Churchill: There are two distinct parties we are dealing with altogether. Pretty well, our home in Bancroft is rural, probably 95% to 100% rural. In Belleville, it's probably just the reverse: It's a city population we're dealing with; a few of them coming from close proximity to the city, but mostly Belleville. Trenton, in that catchment area.

One thing I may say is that I also sat seven years as vice-president of Ontario Housing for Hastings, Prince Edward, Belleville and different areas; Trenton, before it had its own. I found in that area too that we had people who were willing to pay. We always think people are out there for a free ride. There are a lot of people who aren't out there for a free ride. Most of the people in here today don't want a free ride. I found, from my experience in that sector, that a lot of people are willing to pay, quite willing to pay, to get into that atmosphere of living that those homes provided for them: an atmosphere of community with people of their own age and limitations, and also their own expectations. Yes, I think we have people out there who would be willing to pay a higher share to be in those homes.

Mr Villeneuve: You want more autonomy, then, I gather, on the caps; you may be looking after residents who are heavier care than in some areas, and you would like to see some flexibility on those caps. Could you comment just a bit on that?

Mr Churchill: I would like to see that flexibility. Yes, we're looking at different levels of care. We're even looking at different levels of care in, let's say, our home in Bancroft compared to Belleville. It is a tendency, we have found anyway, for our residents in the rural area to keep their loved ones in their homes for a longer time than those who are in the more affluent society.

Mr Villeneuve: And you would have Meals on Wheels and services.

Mr Churchill: We do have, ves.

Mr Villeneuve: One final question: inspections. You touched on it. Yesterday in Ottawa we were told by the regional municipality of Ottawa-Carleton that it was going to be increasing bureaucracy, with Bill 101, at the expense of beds. I hope that's not the case, but inspections, yes. Coming from rural southeastern Ontario, we've had some nightmares with certain homes for the aged which were not up to scratch, and thank goodness for people who cared; hopefully, the situation was corrected.

But the inspection system leaves a great deal to be desired. I'll cite you an example. In the riding I represent, not too long ago, warm fresh cheese curds were considered, by the so-called inspectors, to be bad for your health. I spoke to the Minister of Health, I spoke to the Minister of Agriculture and Food, and they agreed that was all wrong, but it was out of their hands. Sometimes the bureaucracy gets going and it's very difficult to control once they have their hands on the so-called levers of power.

I'm looking for a little more guidance from people like yourself as to what that inspection service should be. To me, that's a very important aspect of Bill 101.

Mr Churchill: Probably Rob will comment after me; he is more qualified to comment on that. In the private

business world, in terms of health and food regulations and stuff—I've always been in the food industry, one end of it or another, and what I have seen is not a uniform enforcing of policy right across the province. In fact, different inspectors come in from Health and the different food departments, and there isn't the same level of verification done by those people. I don't know where it breaks down. I know they're all operating from the same mandate put out by the ministry which they represent, but they close their eyes to one situation in one locale and try to enforce it in another locale

I have found over the years that sometimes, if you tell these guys to bugger off and give them a hard time, they quite often do; not always. The governments haven't changed this procedure, I've found, in 20 or 30 years of doing that. I usually try and work with them, because, number one, I've been a firm believer—in fact, my established business that I have had for 20 years, for a number of years was never inspected by Health or Agriculture and Food. I went to Health and said, "I want my premises inspected." I would like to know that I am running a good, clean operation, within the guidelines set out. Somewhere, I feel, the process breaks down in the uniformity of what it was intended to be. I can't answer that for you.

Mr Rob McLaughlin: I'd like to thank Mr Churchill for placing that tremendous weight on my shoulders at the beginning of having to answer questions and then very adeptly removing that weight from me.

Mr Villeneuve, I couldn't agree with you more. There are some dangers in self-policing, if we can use that as opposed to inspections. "Inspections" is a bad term; "self-policing" probably is too. There are some dangers in that.

Over the course of the years, there have been horror stories in long-term care, no question. I think those horror stories have been dealt with, in whatever fashion. There are mechanisms currently in place under two different pieces of legislation to deal with that.

I see some kind of marriage taking place there, yes, that will work. Hopefully, it will not be—as Mr Gibson alluded to this morning—the old regime of the inspection branch, where one was under the thumb and you walked in total fear of these people. I see whatever structure is formulated as being a collaborative effort on behalf of us, the providers, and the people who are doing the "inspection" or standards enforcement; holding hands and coming to a successful conclusion that's going to benefit the people we serve. If we can achieve that, it will be wonderful.

Mr Villeneuve: It will be in the regulations. Of course, that's out of the hands of the politicians, and sometimes those regulations make us pretty nervous. Thank you very much.

Mr McLaughlin: But being a civil servant, sir, who does normally set those, I have to trust them.

Mr Churchill: Hopefully, I think we'll be getting more in line doing that. At my own grocery operations, I've always told my staff: "Don't expect the customer to buy anything that your mother wouldn't buy. Make sure it's first-class." I think too that if we, as care givers in all

the facilities we have, would bear that in mind, regardless of whatever bureaucracy level we may be at—don't institutionalize it so much that you take the human kindness out of it. Also, don't expect to put people into an institution that you would not live in yourself.

Ms Carter: Thank you for your presentation. I'd like to raise the question of placement coordination, which you raise in your brief. If there's a problem with Bill 101, I think it's partly that it leaves a lot out, and, as you just mentioned, some of that will be made up in the regulations. But there tends to be an assumption that this new placement coordination will not allow choice, and I want to say that that is not the case, that it's very much intended that the consumer's choice will be the main consideration in where a person is going to go. We've had a lot of presentations from homes with ethnic or religious or whatever different backgrounds who were afraid they would not get the consumers who corresponded to their specialty. From what I understand, that will not be the case.

We have in fact heard from placement coordinators in our hearings—we had a lady in Ottawa last night—and it seems to work very well. We've also had presenters who say that there is already placement coordination in their areas and that they're very happy indeed with it. We have asked some of these coordinators whether they see their function changing as Bill 101 comes into force, and they don't see any reason why that would be the case. So I think that although concerns over this are very legitimate, as far as I can see, that is going to work well.

We have the VON following you, and we heard from some VON presenters in other areas who are involved in this function, and—

Mr Churchill: I think it has a function, Jenny, to carry out. In different homes or institutions or whatever care facility you have—in our present situation, the one I can speak conversantly about, which I am connected with, I think we see that job being done. I don't have any great misgivings about that coordinator. I think that in all aspects of the life we're living today, there's some kind of coordinator somewhere pushing the button saying when we do and don't. The only thing is that I also see the coordinator as a person who knows which side his or her bread is buttered on. Sometimes their actions and the responsibilities they carry out can be influenced one way or another. I suppose that's a wrong statement to make when I, as the reeve of my village, also get calls that say, "Can you quicken up the process? My father wants to get in there," or something. I guess the same pressures are put on the municipal politicians that the coordinator would have.

Ms Carter: Well, as a member of provincial parliament—

Mr Churchill: And you certainly deal with that all the time. I want to see you before I go. I have a couple of things I want to talk to you about.

Mr Villeneuve: You came to the right place.

The Acting Chair: I want to thank you for coming before this committee. You have brought to our attention something new, so we thank you for that. We wish you good luck. Mr Churchill: I thank you and I wish you well.

VICTORIAN ORDER OF NURSES

The Acting Chair: Would the representatives of the Victorian Order of Nurses, Eastern Lake Ontario branch, please come forward? Oh, with several other branches, I guess. Would you identify yourself, please, sir?

Dr William L. Gekoski: Thank you for the opportunity to make this presentation. My name is Bill Gekoski. I'm the president of the board of directors of the Eastern Lake Ontario branch of the Victorian Order of Nurses. I'm here today, however, representing not only my own branch but four other branches in southeastern Ontario. If you look on page 2 of the briefing paper we've presented, I'd like to introduce my colleagues from the other branches. Perhaps they would be in a better position than I to answer some of the questions you may have.

The Acting Chair: They're most welcome to come to the table.

Dr Gekoski: We've got our group all here. From my own branch, in addition to me, we have our executive director, Ivan Ip; from the Quinte branch, Mary Lou Workman, president of the board of directors, and June Rickard, executive director of the branch; from Brockville, Leeds and Grenville branch, Judy Roth, president, Kathy Robertson, vice-president, and Joan Bennett, executive director; from the Lanark branch, Gary Rice, the president, is unable to be here, but Karen Thorington, the executive director, is here; and from Peterborough, Victoria and Haliburton branch, Dawn Straka, the president, is here, and Lyn Linton, the executive director, is unable to be here.

The Acting Chair: Welcome to you all. I see a few familiar faces.

Dr Gekoski: I'd like to begin with a brief statement of background information about the VON and then proceed to our position on Bill 101.

The VON was established in 1897 as a non-profit, charitable organization to provide professional and caring nursing services in the community. Initially comprised of only six branches, one of the original ones being located here in Kingston, the VON now has 73 branches across our country. The 33 branches in Ontario provide services available to over 90% of the residents of this province.

Although best known for our visiting nursing services, our various branches offer a total of over 45 different programs, ranging from Meals on Wheels to adult day programs to homemaking to placement coordination service, to a wide variety of specialized nursing services such as cycler dialysis, enterostomal therapy, intravenous therapy and so on.

New programs are generally developed locally, provincial and national standards are developed, and then new programs are made available to our other branches. VON branches are very much locally based, with active volunteer boards that spend countless hours engaged in trying to establish community needs and develop programs to meet

these, often in partnership with other community organizations or with government.

I'd like to begin our comments regarding Bill 101 with some general statements and then proceed to focus on some specific points. The overarching position of the VON on the issue of long-term care reform to which Bill 101 is intimately related is that consumers requiring long-term care services to promote their health and wellbeing should have a choice of needed services delivered in their preferred location by their preferred provider within available resources.

Basic to this position is the need to deal with provision of facility-based and community-based services in an integrated manner. From this standpoint, although the VON finds much that it can support in Bill 101, we also find much that is lacking. Because VON sees the shortcomings of Bill 101 as substantial, we urge the government to postpone acting on this bill until after the release of the long-term care reform policy document, which—I say this perhaps with tongue in cheek—we are led to believe is imminent.

Let us develop our position more fully. We see the changes incorporated in Bill 101 as incremental and not sufficiently comprehensive to appropriately empower the consumer. The bill provides for a number of improvements in service and service delivery which VON applauds, allowing for direct funding grants for the physically challenged, beginning the process of standardization of legislation for long-term care facilities, ensuring consumer access to key information regarding facility services, care and accommodation, ensuring a consumer's knowledge of his or her own care plan and allowing for an appeal process regarding eligibility for service.

However, to fully develop these incremental improvements, the bill should, at minimum, specify similar requirements for chronic care beds and should provide a requirement for residents' councils in all long-term care facilities.

That the government is prepared to proceed with Bill 101 before the long-term care reform policy paper is even released suggests that, despite protestation to the contrary, it remains more interested in institutional care than in developing health promotion and community care options and integrating them with institutional care so as to generate a comprehensive approach to long-term care. Given that the resources allocated to the institutional sector dramatically outweigh those allocated to the community sector, the government's insistence in proceeding with Bill 101 independently of the policy framework for long-term care reform clearly results in the reinforcing of the institutional bias.

I'd like to make some remarks about fiscal accountability. In addition to our concern that the timing of the tabling of Bill 101 implies a continuing emphasis on the institutional care sector, the VON is also seriously concerned that one of the results of the provisions of Bill 101 is the promotion of an approach to fiscal accountability that emphasizes control of resource utilization in the absence of any attempt to measure resource outcome.

Examples in the legislation include, one, controlling the number and type of beds, as well as the associated costs, rather than evaluating the benefit of the facility versus the other care options from a systemic and a consumer perspective. A second example involves promoting a regulatory control model rather than a quality management model. A third example involves failing to consider alternate quality control models such as accreditation. A fourth example involves failing to promote comparability by requiring standardization of data collection with the facility system and across the health care system for evaluation purposes.

If I may turn to planning, the VON is concerned that, by moving ahead on legislation related to facilities independent of the long-term care reform policy framework and prior to local DHC planning input, the government is not following its own direction to develop a strategic, policy-based approach, which is grounded in widespread consultation, to the health care system. Bill 101 allows the government to designate the number of beds, to require certain types and capacities of beds for certain levels of care, service, programs etc but does not reference these requirements in terms of any planning process provincially, regionally or locally.

It is for these reasons that the VON urges that the legislation be deferred until the long-term care reform policy framework is released and debated and the DHCs' planning for long-term care can occur and be referenced with respect to the designation of numbers and types of facility beds.

Resource allocation: Bill 101 appears to ensure the continuation of centralized funding of extended care beds, as there seems to be no reference to chronic care beds and to the separate funding of these beds. The VON strongly urges that the government move away from a policy of centralized, fragmented funding to a policy of district funding authorities which receive a long-term care envelope to be deployed so as to support community-based, in-home services and facility service provision. It is our view that only when such a comprehensive district envelope funding approach is developed will we achieve a significant redirection in long-term care from institutional care to community-based care, and only then will we see the development of flexible, cost-effective services reflecting community need and priorities.

The VON recognizes that the current funding model of per diem funding is a disincentive to caring for residents with complex needs and intensive resource requirements. At a time when the government is considering the need for flexible funding and flexible service delivery models, we argue that it should consider the possibility of multiple funding options for long-term care facility beds.

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We submit that the development of comprehensive multiservice agencies by the VON and by other community agencies funded by capitation may significantly reduce the bed requirements by providing more comprehensive and potentially more cost-effective options in the home. Before facility services are expanded, other community-based services should be considered. By having a locally

administered funding envelope, greater flexibility can be

In addition, utilization of community-based services, such as speciality nursing consultation teams, delivered in facilities should be considered as part of the funding option. For example, a VON—or other service provider, for that matter—infusion therapy team could provide such services in long-term care facilities where such procedures are not required frequently enough to justify the cost of providing this higher level of care on an in-house basis and where the alternative is transfer of residents to a bed designated at a higher and therefore more costly level of care.

The VON also supports the need for a provincial role in long-term care facility planning to ensure the development of provincial standards and requirements for care programs and for assessing community planning decisions.

Placement coordination: The VON is also concerned about how the changes embodied in Bill 101 will affect placement coordination services. Although none of the five branches present here today administer a placement coordination service, this service is administered by eight of our branches elsewhere in the province. We are concerned that, under the provisions of Bill 101, the placement coordinator will have virtually unilateral decision-making power as to placement, where clients may only appeal after the fact.

Given that consumer choice is a key element of VON's position regarding long-term care reform, we find the provisions of Bill 101 regarding placement coordination to be unsatisfactory. We believe it is essential that this service reside in a multiservice environment and not in a long-term care facility, where even the appearance of objectivity and of freedom from possible conflict of interest will be difficult to achieve. The VON urges the government to consider placement coordination in the larger context of the long-term care reform policy framework.

Devolution: We in the VON are committed to the principles of continuity of care, consumer choice and seamless access to services within the available resources. We feel that these objective are most likely to be attained in a context where funding envelopes are provided to district planning authorities and where the planning authority is responsible for all long-term care, facility and community based.

The reason that we are so strongly committed to such an approach is that we believe in the grass-roots approach that communities, when provided with the relevant information, are in the best position to determine their own needs and achieve their objectives within the available resources. If one looks at the history of the VON, our position is easily explicable. This is essentially how we have operated so successfully over the years. We have always counted on local volunteer boards to assess community needs, develop programs to meet these needs and find ways to fund these programs. The local approach has worked for us and has resulted in VON branches each of which has a somewhat different set of programs developed to meet unmet community needs and has resulted in a very large and varied set of programs when the province as a whole is considered.

Let's look at VON's local variability. Each of the five branches represented here today has developed new and innovative programs to meet the needs of its community. My own branch, Eastern Lake Ontario, developed, in partnership with the local Alzheimer society and the Ministry of Community and Social Services, the Kingston community Alzheimer respite and enrichment program, known as the CARE program, to provide respite to care givers of Alzheimer victims and to provide stimulation and enrichment to the victim himself. Established through a vast expenditure of volunteer hours, the program has been extremely successful in meeting important needs. It has also served as a model for similar CARE programs in our Quinte branch, Simcoe branch, elsewhere in this province and in at least one out-of-province branch.

In the Quinte Branch, health maintenance clinics have been established to foster health promotion and to bring services out into the community to individuals who might not otherwise access such services. The Lanark branch, in participation with the Almonte General Hospital, has developed a diabetic education program, another more specific form of a health maintenance and promotion service.

In the Brockville, Leeds and Grenville branch, a very successful home support program has been developed that provides, via a single phone call, access to a whole set of services which assist people in remaining in their own homes: Meals on Wheels, volunteer visiting, home maintenance assistance, income tax assistance, medical transportation, telephone reassurance and other services as well.

In the Peterborough, Victoria and Haliburton branch, an incontinence management program has been developed to help people cope with one of the major problems that often makes it difficult for people to remain in their own homes. The Peterborough branch is also currently involved in developing a very exciting supportive housing program that, among other things, would house the VON branch office directly in the supportive housing facility.

This is just a very small sampling of how, and how effectively, local branches of the VON have operated to assess what is needed in their communities and to do what needs to be done to meet these needs. We have no doubt that a devolved approach to funding will facilitate development by the VON, and by other agencies and organizations, of those services that communities need and can afford. Each community is different, has different needs and has its own set of existing agencies and services. To not capitalize on the richness, diversity and commitment at the local level would seem foolish.

Let me end by noting that the government is talking about creating multiservice agencies. Each VON branch already is a multiservice agency. Let VON branches and other multiservice agencies, existing ones and newly formed ones, continue to work together at the local level by creating district funding envelopes and by combining in these envelopes funds for community based and facility services. We are convinced that such an approach will allow for each community to make whatever tradeoffs it deems best in order to achieve high quality services, continuity of care, consumer choice and seamless access to services within the resources available.

On behalf of the five branches of the VON in southeastern Ontario, thank you for letting us address the committee. Profiles of each of the five branches are included with this brief. These profiles suggest to you the activities, volume, character and so on of each branch, as well as providing you with some idea of the breadth and depth of talent and commitment of those individuals who work as volunteers on our local boards of directors. Representatives of all five branches are, as I said, here and available to answer any questions you may have about our position on Bill 101 or any of the programs or activities of the specific branches.

The Acting Chair: Thank you very much. We have had several of the branches appear before us.

Dr Gekoski: Yes, I realize that.

The Acting Chair: But it is really good to have you here. I'll begin the questioning with Mr Villeneuve.

Mr Villeneuve: Dr Gekoski, thank you very much for outlining what you've done. I think the VON and many other organizations, similar care providers, do it in a very quiet and a very efficient way. In your second to last paragraph you say, "Let VON branches and other multiservice agencies continue to work together." Do you see some interference, directly or indirectly, in Bill 101?

Dr Gekoski: No, in all fairness, not directly in Bill 101, but of course we're still so uncertain about the details of the long-term care reform policy framework and the discussion as to whether there will be a single comprehensive multiservice agency or an umbrella with subgroups and so on. We don't know, but of course we are in favour ultimately of a position that allows the groups that already are doing it to continue doing it and that does not try to reinvent the wheel and overbureaucratize the system.

Mr Villeneuve: I know your areas cover large portions of rural eastern Ontario as well as whatever urban areas are in eastern Ontario.

Dr Gekoski: Yes, we do.

Mr Villeneuve: Fiscal accountability, and I see you've put that kind of as number 1, is of great concern; as we know, governments at all levels have not got that many dollars. In the four items that you put in there, you touch on controlling the number and types of beds as well as associated costs.

Regarding autonomy, we would certainly like to see the autonomy stay with the local organizations that know best, without any shadow of a doubt. But where you say in your number 2, "promoting a regulatory control model rather than a quality management model" is of great concern to me. Quality should be number 1; caring people looking after people who need care is what it's all about.

The bureaucracy will be taking over. We were told, as I mentioned to the previous people that made a presentation, that Ottawa-Carleton foresees bureaucracy taking over the money that maybe could be used for beds. Do you see some of that here? You've itemized this, so maybe you could refine that a little bit.

Dr Gekoski: Surely. I guess our concern in part is that we think that quality management is essential and that obviously the government has to be assured that all facilities and

all community based organizations have a mechanism for quality management. That doesn't mean the mechanism has to come down from the top and be the same everywhere. I think that's the concern some of our people have, that it's simply going to be dictated down from the top and not be flexible to the kinds of different situations that exist in different localities and in different institutions.

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After all, I think the assumption is that the majority of institutions and community organizations are already doing a good job. Sure, there are some that aren't and we have to look after that as a society, but the notion of a single quality control mechanism across the whole province doesn't seem to us to be reasonable.

Mr Villeneuve: It boils down to autonomy and you covered it well by saying the local people know what the needs are and they find ways of funding them.

Dr Gekoski: That's right.

Mr Villeneuve: Let's try and leave as much of that in place as we can.

Dr Gekoski: Exactly. I gave you the example in Brockville of the home support program. That kind of a program isn't needed in Kingston. The Senior Citizens Council in Kingston has done a wonderful job with that set of needs. Every community is different, and certainly the legislation has to allow for individual differences across communities.

 $Mr\ Villeneuve:\ You've\ made\ your\ point\ well,\ doctor.$ Thank you.

Mr White: Thank you, Dr Gekoski. I wanted to pick up on a couple of points: first, in terms of the placement coordination services. As you're probably aware, in many of the areas where they're in existence in the province they are either informed, directed or directly involved with the VON, and the VON is very clearly the leading agency throughout our province in placement coordination services.

Where you make reference to the facility base, frankly, you read the legislation—it looks as if somehow that placement coordination service is directly sited in that institution, but in fact it's a community-based service, the services we have presently. Of course, those services will be the ones that will undoubtedly be funded.

Would you be in favour of having that mechanism, that community-based information, that multiservice or multi-disciplinary committee that informs the PCS, included in the regulations so it's really clear that's the direction of the province?

Dr Gekoski: If I understand the question correctly, and this is not an area I personally have a lot of experience with, because in our own area we don't have the placement coordination service, I would think it needs to be covered in both the legislation in front of us today as well as in the legislation that will follow from the long-term care reform policy statement. We believe it should stay in the community and not be based in the facilities. Maybe we've misread the legislation there, but that was our sense.

Let me just ask if—June Rickard, the executive director from the Quinte branch, I think she's perhaps better informed than I am on this particular issue. June?

Mrs June Rickard: I think the comment-

Mr White: You have to sit closer to the microphone.

The Acting Chair: Just come up to the desk and identify yourself.

Mrs Rickard: I'm June Rickard. I'm executive director of the Quinte branch, based in Trenton. I think our comment in the paper arose from our desire to see that objectivity maintained. Most of the placement coordination services, as you just indicated, are presently community based and we're very concerned that they remain there.

Mr White: Absolutely.

Mrs Rickard: I see this as being a key role—and if we can avoid the conflict of interest that would arise if in fact they moved into the facility, whether it be hospital, nursing home or whatever.

Mr White: Sure, and you'd be in favour of that direction being in the regulation.

The Acting Chair: Excuse me, Mr White. Would you permit the parliamentary assistant to just clarify that. He's asked to—

Mr White: I'm wondering if I could pose my next question before that clarification.

The Acting Chair: All right, if you can do it quickly, because we are close to the time.

Mr White: Absolutely. The issue you bring up about the institutional side being addressed first—I'm wondering, in terms of the next long-term care legislation, there are presently barriers to interaction with the institutional facilities. You bring up the issue of providing services to institutions that are not capable of providing in-house. So you'd also be in favour with that next piece of legislation of ensuring that those services are available to people wherever they are in the community, including in an institution.

Dr Gekoski: Yes, and within each community let the relevant facilities and organizations work out best how to do it, rather than trying to work out a formula in Toronto that then would be applied across the province.

Mr White: Thank you.

Mr Wessenger: If I just might clarify, existing placement coordination agencies will continue to perform that function, and in the long-term, of course, there's the whole planning process under the district health councils, which will deal with such questions as the nature of all these service agencies and so forth. I assume that, as you say, as we have this flexibility and difference throughout the province as different communities have different needs, I'm sure local district health councils will come up with differences as well, in their recommendations.

Dr Gekoski: Our plea, though, is that the facility based and the community based be dealt with in the same envelope. That's our bottom line in terms of—

Mr Wessenger: I can assure you, the placement coordination aspect—it obviously has to explore both the community based and the facility based and it has to deal

with both. I think it's even in our legislation now in the fact that it requires it explore the community-based options.

Dr Gekoski: Thank you for that clarification. I appreciate that.

Mrs Caplan: I think one of the problems we've seen with this legislation is that so much of it is left to regulation, which avoids the opportunity for participation and scrutiny. Once the legislation is in place, the process for establishing regulation is internal to government and often is even lacking in the kind of opportunity for discussion and consultation that—other than legislative committee hearing takes.

So we've heard from a number of deputants the concern they have that there's not enough explicit in the legislation that will clarify what's going to happen by regulation. We are encouraging the government to consider some amendments and put into the legislation some of those things the parliamentary assistant has assured us will be dealt with by regulation.

I want to thank you. Your brief is very comprehensive. We have heard from a number of VON organizations across the province. We're very aware of the good work that is done, but one of the debates we've been having at this committee has been—and Mr Villeneuve referred to it as well—the concept of the regulatory model versus the quality management model and the outmoded, outdated, big-stick inspection input, or after-the-fact attempt at quality control rather than a—I'm not sure that "newfangled" was the word Mr Owens used earlier—

Mr Owens: No.

Mrs Caplan: Well, it was something like that.

Mr Owens: That's clearly your word.

Mrs Caplan: No. The word I have been using is-

The Acting Chair: I know there's going to be a question here for the presenter.

Mrs Caplan: That's right—a more modern approach to outcome measure, which would include an appropriate place for accreditation.

I'd like you to take a few minutes and tell us why you believe it's a better way and how this legislation could be changed to bring about a more quality-management-focused approach and an outcome, results-oriented, positive accountability model. Really, I'm asking you to help convince the government that is the right way to go.

Dr Gekoski: Right, okay. I appreciate the intent of your question and I'll try to make my response brief because it's a big question. Especially as a researcher in gerontology, I don't usually answer questions like this in two minutes, but I think there are some comments I can make that are brief.

The Acting Chair: Please give it your old college try. **1440**

Dr Gekoski: Right. I think it is important to allow quality management frameworks to develop in specific settings, and not to impose one from the top. At the same time—and this is in our brief—obviously the provincial government has the ultimate responsibility for quality, so there has to be some mechanism to make sure that a quality

management approach is undertaken in each district, in each facility and for each community-based organization.

The forms quality management can take could be very different. I appreciate the concerns that have been raised this morning regarding inspection and the kind of climate that can create. Perhaps one solution is to have some kind of an "inspection"—and I use that word in quotes advisedly—of a local level through a part of the DHC rather than doing it from far away, but it would still—

Mrs Caplan: Peer review?

Dr Gekoski: Peer review—that's fine. We're used to that in the academic world and I think it works very well. There still have to be, of course, provincial guidelines, though, as a bottom line, to guarantee that there are in place appropriate quality management techniques.

Mrs Caplan: Would you be comfortable—

The Acting Chair: No, I'm sorry, I just have to go on. I do thank you very much. I hate to be the heavy. I know there are many things we could discuss, but we're getting a little behind.

Dr Gekoski: No, I appreciate that. We all learn from each other's presentations. Thank you.

The Acting Chair: Thank you very much.

COMCARE (CANADA) LTD PARA-MED HEALTH SERVICES

The Acting Chair: Would the next group, Para-Med Health Services, from Kingston, please come forward and make yourselves comfortable at the table.

Glad to have you here this afternoon before us. Would you please identify yourselves for Hansard record and then make your presentation.

Ms Vicki Johnston: I'm Vicki Johnston. I'm the area manager for Para-Med Health Services in Kingston.

Ms Janet Szczukocki: I'm Janet Szczukocki, the manager for Comcare (Canada) Ltd in Kingston.

Ms Johnston: Thank you for the opportunity to participate in these presentations regarding Bill 101 today. Janet and I are members of the Ontario Home Health Care Providers' Association, which represents most of the private home care agencies in Ontario.

Karen Gill, who is the manager of All-Care Health Services, can't be with us today. However, we represent the three Kingston private agencies and we work closely together and share a common commitment for training and education as the key to quality service provision to our clients.

Although Bill 101 principally deals with health care in facilities, it will help determine many long-term care direction initiatives. It appears that this bill is the only legislation required to implement long-term care redirection. From the private agency perspective we are participating, as this may be our only opportunity to speak in favour of private sector participation.

We have closely followed the government's long-term care redirection. The central thrust in the redirection is to help people stay in their homes longer through expanded community-based health care rather than to be cared for in a health care facility. We strongly support such a direction where community care is an appropriate choice. Our experience has shown us how people benefit from care at home for as long as possible. This thrust is confirmed in the draft legislation of Bill 101. Bill 101 would ensure equitable access to long-term care facilities through placement coordination only after all options for community care have been exhausted.

This direction is based on the premise that there will be more care available in the community, but there are as yet no plans or funding in place to expand community-based care to the extent that would be necessary to make home care available as a true alternative to facility care. In fact, we think the committee should take note that while government has declared its aim to expand community-based care, the Minister of Health has considered severely limiting—virtually eliminating—private agencies who provide about 45% of home care services.

If the government wanted to enforce a public sector preference by directing all new business to public sector agencies, no legislation or regulation would be needed to force our members out of publicly funded home care; it could be done simply by not giving us any more business. Of course, this could force many of our member companies into failure and bankruptcy.

It is extremely important to note that in Kingston alone our agencies provide service to approximately 1,000 clients. We employ approximately 700 health and support service workers in this community; that is, Kingston. Almost all of them are women. Many are visible minorities and about half of our employees work part-time in order to take advantage of flexible schedules to fit their families' needs. In Kingston and other areas, most of management are women, and in some cases entrepreneurial women are owners.

The impact of forcing private agencies into failure should be clear. It would result in job loss at a time of high unemployment, job loss for those who can least afford it. Although some of the private agency workers will find jobs with public agencies, there will be jobs lost and considerable job disruption.

There will be loss of choice for consumers. Having a choice between different types of service providers is important. It is just as important as having a choice in physician or hospital care.

There will be a loss of flexibility. Private agencies have developed in response to the need for 24-hour service, seven days a week. They have developed in response to the need for service provision in geographically isolated areas and the need for no minimum limit on service. Finally, private agencies have developed in response to the need for specialized service.

In Kingston, private agencies provide specialized service in IV therapy, ventilator care and head injury. There is evidence that deprivatization will result in a rigid bureaucratic system. In Manitoba, the provincial government is moving away from a totally public system because it has become inflexible and too costly.

Forcing private sector agencies into closure will mean increased cost to taxpayers, since the deficits of public sector agencies have historically been covered by the

provincial government. It is important to recognize that government home care programs purchase home support services from both the private and public sectors for the same cost. The cost of purchasing other services from the private sector is often less than purchasing from the public sector. When private sector agencies provide exactly the same services with comparable quality to the public sector without deficit financing, it can only equal efficiency.

We believe that ownership of agencies should not be the criterion for selection of those who will provide service in the future. We believe that accountability for service—a combination of quality, cost and availability—should be the criterion for service delivery. We support the development of province-wide standards and accreditation procedures for all agencies participating in an integrated long-term care system.

With regard to standards, there is another section of Bill 101 on which we wish to comment. An amendment would allow the Ministry of Community and Social Services to provide payments directly to disabled persons who wish to self-manage their funding and attendant services. We recognize the change is aimed at assisting adults with disabilities to realize their ambition to live as independently as possible, and we applaud that ambition. The disabled person self-managing his or her own care should, however, receive care which meets provincial standards, and the province should know that its money is being used effectively. Workers who provide that care should be protected against loss of benefits like workers' compensation, unemployment insurance and Canada pension. Workers should continue to receive ongoing professional training as if they were working for public or private agencies. Clients like ventilator-dependent quadriplegics should know their care givers have the most up-to-date training possible. We urge the committee to recommend that the framework for self-managed care include safeguards for both clients and workers.

We have consulted as many people as possible involved in policy development to try to understand why the government would want to limit our participation in publicly funded home care. A recent letter from Premier Bob Rae to our field staff confirmed this direction. The Premier said, "Nothing that we heard during the consultation indicated that we should change this direction"—that is, a continued preference for not-for-profit services. He continues, "We are now looking at how not-for-profit services can be put into place." Yet clients, particularly home care programs, have publicly expressed their support and desire for a pluralistic system. They have provided evidence to the Minister of Health of why a future long-term care system will require a balance of public and private sector agencies.

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In conclusion, we urge the standing committee and the provincial government to look at Bill 101 in the total context of long-term care redirection. You must consider how implementation of Bill 101 will affect other aspects of long-term care redirection, specifically home care. We strongly recommend that a balanced system between public and private home care providers continue to exist for the benefit of the client.

The Acting Chair: Thank you very much for your presentation. It is the government's turn to go first. Mr White.

Mr White: Thank you very much for your presentation. I think you've articulated some very strong concerns. You are also aware, though, that this piece of legislation deals primarily with the institutional care and with the many homes and facilities that have been operated under different pieces of legislation from time gone past. In fact, privately owned nursing homes for the most part are very supportive of the legislation because it puts them on a much more equal footing with the not-for-profit services. In this regard, in this perspective, the issue of not-for-profit and for-profit is brought together in this legislation. Are you afraid that with the placement coordination services being operated by non-profit services, that might affect your nursing services?

Ms Johnston: No, not at all. In fact, in Kingston we already have a system where we have a placement coordination service that's operated out of home care. I don't see that that will implicate us in any way. I guess our reason for commenting at this time is simply, again, because the legislation does not have a lot of clear direction. I think I heard Elinor Caplan mention that it's not very explicit. And we don't want to miss the opportunity to comment on the fact that we feel there should be a balanced system in the community and that there are implications in terms of community care. It seems a bit disjointed, I guess. If you are going to look at facility care and changes in facility care, it's hard to imagine how you can do that without looking at community care as well.

Mr White: How has your business gone in Kingston? I know that in many areas of the province, private nursing services have really done exceptionally well in the last 5 to 10 years. What has your experience been like here in Kingston?

Ms Johnston: We have been in Kingston for 13 years and certainly we have seen some changes over the years. I think in Kingston the private sector would probably have about 45% of the share of public funding through home care, and certainly we have experienced growth.

Mr White: So you've experienced continual growth over the last number of years.

Ms Johnston: Yes, and that, I think, is because we have been responsive to the needs in the community, as other agencies have as well.

Mrs O'Neill: I don't think you should say with any hesitation that you've experienced growth. I think that it speaks for itself that you must be providing the service, that you must be providing it in the way the community wishes it, and in a cost-effective manner, or your business wouldn't be growing. That's what I have difficulty with. We have had a lot of people in your same circumstance present to us. Last night the group in Ottawa said that members of the government were suggesting they were shooting at shadows. I tend to have my thoughts more in your court. I don't think you're shooting at shadows.

Can you tell me how you were notified, or was it just through that Premier's letter, that there is a preference for non-profit that seems to be taking a new profile? Ms Johnston: I think that when we read Frances Lankin's announcement, there is clearly a statement in the announcement that indicates that there will be a continued preference for not-for-profit. In fact, in one of the announcement copies that we have, it says they will only utilize not-for-profit in their long-term care redirection. We became alarmed at those types of statements and started to write letters to the Premier and since that time have received that kind of letter back from him.

Mrs O'Neill: Have you noticed any changes in your dealings with the municipalities in this area regarding the picking up of new clients, or is everything just about the same in this area?

Ms Szczukocki: I find that it's basically the same. We haven't experienced a lot of change. We have had support in this community from our home care director, who has expressed the feeling that they are very happy with the choice they have because each service provider is able to provide their own unique services that maybe one other one doesn't. We're always keen on developing new services, and they are happy with that choice.

Mrs O'Neill: I am glad to hear that, because that's not the case in every municipality. I'm glad you brought forward to us the fears that you have regarding the hampering of flexibility, the costing fears you have of a new system. And I'm glad you brought forward the attendant care component of Bill 101, which arises, of course, from the direct funding. All of those things, I think, we have heard from other people. They've taken a new profile. I think in clause-by-clause we'll have to look at them.

Mr Villeneuve: Thank you very much, ladies, for your presentations. I've also had in my riding serious concerns expressed by the private sector care and service givers, and I think justifiably founded, as you've expressed in your brief.

You, I understand, are very close to 50% of the care and service givers of the Kingston area here. Would you be able to comment as to whether the so-called non-profit—and that has a connotation to it that is not quite right and I compliment you for not using it in your brief except for quoting the Premier. I think we've got to get that straight.

In most instances, would the work that you're getting be the average, run-of-the-mill type service, or is it heavier service that seems to be sent in your direction with anticipation that you would provide that service, again, for no more and maybe less cost?

Ms Johnston: I think certainly there's a mix. We would definitely have our share of average, or whatever you would call it: older clients who may require general types of home support work and that sort of thing. But we also get much more difficult or complex cases. Also, say, in terms of head injury and different programs like that, where we would provide additional training and pick up the costs for that training, it's not uncommon for public sector to receive additional funding for their training. We tend to end up providing that sort of training and picking up the cost for that, as well as spending additional time, in the head injury program again, meeting with various occupational therapists and different other

people involved in the program. Those types of costs are picked up by our company.

Mr Villeneuve: I think the clientele, the public out there, wants to have a choice. You people are providing service around the clock where in many instances the so-called not-for-profit, again using a cliché from the government, seems to have a little trouble getting people to work on those weekends when you people are called upon. Can you maybe comment on that one?

Ms Johnston: I think that they do, actually. I think in our community we're seeing an expanded role for VON and other not-for-profit agencies to meet that demand and to be more flexible, and I would say that we've seen a response to that need.

Mr Villeneuve: So it's been reasonably fair to this point. You're simply expressing your concerns and wanting them to be on the record. I thank you for that.

The Acting Chair: Thank you very much for coming forward this afternoon. We appreciate your taking the time to appear before us because we take into consideration everyone's concerns, and we thank you for coming.

Ms Johnston: Thank you.

CARLA HORSTEN-CERISANO

The Acting Chair: The next person on the list is Ms Carla Horsten-Cerisano. Welcome to the committee this afternoon. You may begin.

Ms Carla Horsten-Cerisano: I am—or was—a mother of two handicapped boys afflicted with muscular dystrophy, Duchenne.

Last November, Frances Lankin, in her statement of November 26, stated:

"Finally, our fifth goal is to make direct payments to adults with disabilities so that they can purchase and manage their own services. This goal addresses the central importance to consumers of maximizing dignity, independence and control over their own lives."

It has come to my attention just recently that a pilot program is already established in Ottawa where terminally ill cancer patients have received up to \$10,000 to manage their own services and that it is working very well.

The government advocates the central importance of independence for the handicapped adult but puts restrictions on its use as to from whom services can be purchased. Care giving services cannot be purchased from a parent or other relatives.

For 15 years I have cared for my two handicapped sons at home, watched over them and helped them manage their terminal illness, muscular dystrophy. As a single parent working full-time, I found it extremely hard financially to be able to give my sons the care and attention they needed and still need and the quality of life they deserve.

When we read that this bill will give the handicapped person freedom to purchase services, we were relieved that there was finally a chance for me to maybe give up my full-time job and care for both of them at home full-time. For the past year my son Christopher was completely bedridden and on oxygen, while Dino is wheelchair-bound and bedridden 24 hours, day and night. We found over the years that home care was not willing to give Christopher, and later Dino, the care and comfort they needed and only I, as a mother and care giver, was aware of this. It would have been a tremendous relief to be able financially to buy the services they both needed from different sources in the community.

Here are but a few samples of what we had to endure: When Christopher came out of the hospital and needed oxygen daily to help him with his breathing, he needed a hospital bed, which we received through home care for a few months. But one day I received a phone call that this service would be discontinued and we had to buy our own hospital beds, both for Dino and Christopher, at a cost of \$1,900 of our own money.

Physiotherapy is crucial for a young person and for a young adult with muscular dystrophy to keep legs, arms and hips straight and the head flexible. We can only get one visit per week from home care. So many times I asked for at least two visits per week but was refused. I was told to do the passive exercises myself with Christopher and Dino, which I now do. I was told years ago by one of the physios, when Christopher was still straight, "It's no use doing exercises on Christopher because he'll never get better," and for years that service was discontinued. As a result, he could not straighten out his arms and legs and had excruciating pain in his back.

We asked home care to arrange proper seating at Kingston General Hospital for Christopher's wheelchair because he had pain and discomfort when sitting upright in his electric wheelchair. He was refused access to the seating clinic at KGH. We were told to go back to the person who had done the original seating in our home. Christopher refused because it was not done right in the first place, and this person operated out of St Mary's of the Lake Hospital.

As Christopher's health deteriorated and he begged me to quit my job and stay home with him, I tried every possible avenue to stay home. I tried to obtain mother's allowance, I tried welfare, I tried unemployment insurance, but I always stood before closed doors. I asked Attendant Outreach to send someone out in the evening or at night—I am a night desk clerk at a hotel—but not enough hours were available and the women do not work after 11 pm, I was told. I tried the Red Cross for help and was told they do not provide babysitters for nine hours at a time through home care but that we could purchase their services and pay the full rate per hour, which is more than I earn per hour.

Meanwhile Christopher asked more and more for me to stay home with him. It was agonizing for me to leave him and Dino every evening to go to work. He offered me his whole pension cheque, which I could not bring myself to take. I had to keep on working, hoping against all odds for him to be all right for the time I could not spend with him. I depended wholly on my son Ricardo's help in the evening to be with his brothers.

Christopher chose not to be placed on life support, a ventilator. Christopher died last December, at home, at the age of 25, when I was at work, and for the rest of my life I'll live with the pain and regret not to have had the chance

to spend more time with him and to be with him when he needed me most

Next month my son Dino, 18 years, has to have his back operation done in Ottawa, the Luque procedure, which can't be done here in Kingston. Already I feel the financial strain to provide the best possible care for him. He decided to give his own blood for his operation because of the AIDS scare. This can only be done in Ottawa at the Red Cross head office, so once a week for five weeks we have to make this trip to Ottawa and then we have to rent a van two times to transport his electric wheelchair to Ottawa for changes to be made there after the operation. All this will set me back at least \$500, and I only earn a little more than minimum wage.

I've been told that it will not be possible for the handicapped person to buy the care services from his family, as family would misuse the funds. I cannot understand how the government can come to this conclusion. I urge the government not to restrict but to let us parents provide long-term care at home for our family members.

I mentioned before that a pilot project is already under way in Ottawa. I ask respectfully for this program to be extended to all families who are willing and able to provide long-term care at home at a fraction of the cost compared to what it would cost placing him in a long-term facility.

The Acting Chair: Thank you very much for coming here. I know this has been difficult for you, and I hope that you will agree to answer questions of the committee.

Ms Horsten-Cerisano: Yes.

The Acting Chair: I'll begin with Ms Caplan.

Mrs Caplan: It's so important for us on the committee to hear from families and from people who both require the care and are trying to keep loved ones at home. I think many of us have had different experiences, usually with our parents or in-laws and sometimes with children, in seeking out care and services. I think it's been important for the committee to hear from you the struggles you've had in trying to find appropriate care for your sons.

This particular piece of legislation deals primarily with institutions, with the one exception, and that is the option for direct funding, and I honestly don't know whether that direct funding as proposed here would solve your problems. I think you've been very, very articulate. I don't have any particular questions to ask you, except that obviously you're concerned that the direct funding would not serve to solve the problems your son has experienced.

Ms Horsten-Cerisano: Well, I think it would, because then I could stay home and look after Dino now full-time instead of going out to work full-time.

Mrs Caplan: So you believe that, as proposed, the option in this bill that would allow for direct funding would help your son to buy the services in the community?

Ms Horsten-Cerisano: Yes, definitely. He could look at different companies.

Mrs Caplan: I'm glad you've explained that. We've heard from many people who've said that they think it will help. Right now it can be provided by order in council, and my question is, do you have anybody you're working with

at Community and Social Services to try and help until this legislation comes into place?

1510

Ms Horsten-Cerisano: I approached them once and they said there's no money available for that kind of thing, just lately, four weeks ago, just before Christopher died, and after that too. They don't give much information out, in Kingston anyway.

Mrs Caplan: Let me ask the parliamentary assistant if there's any advice he could give to this family. I know the parliamentary assistant for Comsoc is here.

Ms Horsten-Cerisano: It's not just my family. There's many. There are about five families in Kingston with children with muscular dystrophy.

The Acting Chair: Mr Hope, would you have anything to say on that?

Mr Hope: Because we're dealing with a particular case, it's very hard for me. I read this before your presentation. I took one of the staff and we went outside to have a conversation and I am looking for detailed information about what went on around this. I don't have any specific answers for you.

We're hoping the changes in the act will provide that, but I still question, the same as what Elinor just questioned, why wasn't somebody pursuing an order in council for direct services and the services to be there? There's a lot of unanswered questions that I have, and I can only assure you that we'll look into what you've brought here in this paper and we'll investigate what all has happened around this case in particular. That will be strictly between yourselves and us, the conversation. That's not really for public information. That's between the client, yourself as an acting partner of the client, and the government, to make sure what happened around this particular case.

There's just a lot of unanswered questions I had, and I've already stood up and tried to get some of them answered, but as soon as I get more answers about the specifics of this, I'll definitely make sure we get in contact with you.

Ms Horsten-Cerisano: Will you keep in contact with us?

Mr Hope: Yes. I have your phone number. Everything on the bottom is appropriate?

Ms Horsten-Cerisano: Yes. Now, these services: Does that include purchase of equipment, or is it just for services?

Mr Hope: That's why I need to take a whole investigation and look at what all has been done around this particular case, talk to the case manager who's been dealing with it and find out particulars about what all's going on. There's a lot of unanswered questions here that I have in my head. The order in council is one that's really an unanswered question.

Mrs Caplan: It may be possible, but you'll have to work with them and find out.

The Acting Chair: Mr Villeneuve.

Mr Villeneuve: My questions will be brief, simply to thank you, Ms Cerisano, for being here. I'm sure it was not

easy. We are subject as politicians to all sorts of legislation and regulation, but try as we may, there are always people like you with a situation that is quite unique, and the order in council is the route. However, many people are not aware of this, and that's where you get the runaround from the bureaucracy, which you quite obviously got for a long time. I suppose they could have but they didn't feel it was their particular job to bring it to the minister for an orderin-council decision. We cannot accommodate everyone in regulation and legislation. There are always cases like yours which get missed. That's why you have then to deal on a one-to-one basis with your particular problem, and hopefully common sense prevails. In your case, common sense looks like you should be at home with some support from government assistance to look after your own children. That's common sense.

The Acting Chair: Excuse me. Mr Owens, did you have anything to say on this?

Mr Owens: Absolutely. As I read your story and listened to you, it reminded me of a situation I dealt with in my own riding and am continuing to deal with, with a mother, again a single mom, dealing with two severely disabled kids. There is a process, if I can be helpful to Mr Hope in this issue. There is an agreement called a special services at home agreement which will provide up to \$10,000 a year. We don't need to go through the order-incouncil process, which can be quite arduous. I can again be helpful to Mr Hope that the process does work. Hopefully, we'll get in touch with the local member in this area and get this process under way immediately for you.

What you can do is to negotiate the number of hours with respect to nursing care versus home care, based on assessments. It doesn't immediately answer your question with respect to having yourself which, in the best of all worlds, would be the good thing to do because kids need their moms. You're right; you know your kids and the kinds of things they need to have done for them in order to make them not only comfortable but to have a good quality of life. If Mr Hope needs any assistance with this, I'll certainly be willing to help him with that. Thank you for your presentation.

Ms Horsten-Cerisano: Thank you.

The Acting Chair: Thank you very much, Mr Owens. That's very useful. I noticed that there was a hand up in the audience. While I cannot accommodate your speaking, maybe you can speak with the parliamentary assistant afterwards. Thank you.

OMNI HEALTH CARE LTD

The Acting Chair: Would the next presenter, Omni Health Care Ltd, please come forward and take your place at the table. I ask you to identify yourself and then make your presentation. Welcome to the committee.

Mr Fraser Wilson: My name is Fraser Wilson from Omni Health Care. We represent eight nursing homes in the province of Ontario. Our head office is based in Peterborough. We have four nursing homes in Peterborough and surrounding area. We have a home in Napanee, one in Cornwall, another in Almonte, which is close to Ottawa, and we have an eighth facility in Aurora.

I'd like to take this opportunity to thank you, the members, for hearing our concerns. We are here to endorse the presentation prepared by our association, the Ontario Nursing Home Association. I have listened to most of the comments you have heard today and I'm going to take a rather more informal approach to this. I don't want to reiterate everything that has been said today. I agree with a lot of what has been said, and I will make specific comments to some of the areas I would like to bring to your attention.

In principle, we support Bill 101. Basically, as alluded to by several presenters today, we have much difficulty with the fact that, to this date, we do not have a contractual agreement. We don't know what the expectation is of long-term care facilities in order to accommodate level of care through the province of Ontario in every long-term care facility, as opposed to nursing homes specifically.

We're also concerned with the fact that there has been no specific announcement as to the funding that is proposed for long-term care. Not knowing what the contractual agreements are going to be, not knowing what the funding is going to be, we feel that we are dealing with uncertainties and very global concepts, the concepts of which we can agree with for the most part.

I would also like to endorse the comment that was made by the home for the aged earlier. We would like the opportunity to be able to respond to the funding model when it's formalized, and also comment on the contractual agreements that we will ultimately have to abide by.

Specifically, with the contractual agreements: As stated previously, the contractual agreements are moving away from the insured services. It moves away from the universality of health care. Basically, we're not opposed to that, under the assumption that all long-term care facilities will be working within the same contractual agreement.

Basically, what has happened over the past is that nursing homes, through legislation, regulations and compliance management, have had to adhere to certain standards instead of regulations, as to those of homes for the aged. To worsen that situation, there has been a very significant difference in the funding between the two long-term care facilities.

We are very supportive of the fact that there is going to be equitable funding between all long-term care facilities. It has been very necessary through the years, and I think it can only better the care that will be forwarded to residents or the recipients of that care.

As far as the enhanced accountability is concerned, we don't know what is within these contractual agreements. We are certainly not opposed to bettering the care; we're not opposed to giving more nursing services, but where we have a large problem is that there's nothing in Bill 101 that makes the government accountable for supporting those increased levels of care with appropriate funding. There needs to be an accountability.

The last three years are a good example in that all long-term care facilities, including nursing homes, have had to operate at levels that are less than inflation. We've been underfunded. We've been asked to continue the level of care that we've had in the past, and it is becoming increasingly more difficult to adhere to those levels of care.

In the event that the funding is not matched, we would suggest that Bill 101 provide some sort of flexibility that would allow us to prioritize the care to be provided to the residents at the end of the day. Whether it be a reduction in staffing, which is much the same as hospitals have right now, if the funding is not there, we have to have flexibility in order to control our costs.

There have been several comments made today in regard to the enforcement of these contracts. From what I can hear from the members, I don't see a lot of support for the sanctions that are proposed in the bill. I have heard comments to a trusteeship. Quite frankly, nursing homes have been operating for some time under compliance management, which is an established set of rules, regulations, standards under which we have to comply. We are inspected by a compliance officer whose job is basically to ensure that we are complying with the set standards. In the event that we do not comply, then the opportunity is extended to the facility to rectify the situation or at least give the rationale behind the situation.

1520

It is our position that the system that is in place with nursing homes right now works very well, and it is not militant in nature. I think pursuing sanctions would be detrimental to resident care at the end of the day. If funding is withheld from a facility, it's those remaining residents who are in the long-term care facilities who are going to be hurt by such sanctions. I don't believe there is any need to further increase the powers of the compliance officers. I really do believe that compliance management, as it is in place right now in nursing homes, is a very adequate system of resolving disputes.

There has been much controversy over the placement coordination agencies. I believe one of the main concerns that has stemmed from that is the fact that the bill, as it stands right now, does not provide us with any specific details as to what their purpose will be. I think that's why you're finding so many of the respondents here making comment to it.

We are of the opinion that there are placement coordination agencies in place in a lot of communities at the present time. The parliamentary assistant has referred, on several occasions, to the one that is in place in Kingston. It is our understanding, from the proposed bill, that there will be another level of bureaucracy that would either replace or supersede the one in place. We would strongly suggest that the one that is in place be utilized. It has already been established that there has been a lot of money, especially in the Peterborough area, invested in computer systems etc, and to be quite frank with you, the system really is working quite adequately in the Peterborough area.

In the event that the agency is going to outline to potential residents of long-term care facilities its direction as to which facility it would be, there have been many comments today about the notion of the right of choice. We would endorse that, and from what I can hear in this committee, it

is well endorsed by the committee that there should be the right of choice.

Also, there has to be the ability for the facility to appeal a placement that is suggested by the agency, the reason being that if we have a resident who we certainly do not feel is capable, we can safely care for that person. The example that was cited earlier is if you had a 350- to 400-pound resident and you don't have the capacity to care for that person. There's a potential danger if he or she goes into your facility and you don't have the appropriate equipment. We ought to be able to have an appeal mechanism to stop the placement and perhaps suggest an alternative placement.

The one comment that there have not been very many comments on today is the fact that nursing homes already participate in the care plans. Everybody was assessing long-term care, homes for the aged, charitable homes for the aged, nursing homes were all classified last year. We would hope that in long-term care reform there is not going to be too much emphasis on the paper process. There is already too much onus on the paper process. If it's not documented, the care isn't provided. Unfortunately, there is a severe price to pay for paperwork. That is a reduction in care. I would seriously suggest that moves be taken to try and limit the paperwork and enhance or try and maximize the hands-on care that is extended to the recipients of the care.

I'd just like to sum up, then, that we are in support of Bill 101, as is our association. We have made brief comments on proposed changes of where we have problems with it. We would ask that you act expeditiously in getting the contractual agreements formalized so that they can be reviewed by the participants and we have some sort of indication of what the proposed funding is going to be for long-term care reform.

I would like to thank you for the opportunity and would welcome any questions.

The Acting Chair: I thank you very much for coming this afternoon. I do detect, now and then, a lovely little brogue that comes through.

Mr Fraser Wilson: There is a brogue.

The Acting Chair: It's nice to hear. I'll begin the questioning with Mr Villeneuve.

Mr Villeneuve: Mr Wilson, thank you for your presentation. I gather that three words would summarize why you're here: funding, compliance and placements, not necessarily in that order. You're the chief financial officer of eight of Omni's health care nursing homes. Why are the so-called non-profit nursing homes receiving more funding from the government? Can you explain that, as the chief financial officer?

Mr Fraser Wilson: I believe that it has happened over time. The major discrepancy between the two facilities is the fact that homes for the aged are able to get a top-up from the municipality. As one of my predecessors alluded to, they get 30% of their funding from the municipality. In the event that there are any expenditures over the 100% cap, that is also picked up by the municipality.

Both those top-ups are not extended to nursing homes. Basically, right now we are operating at a level of \$77 per

resident per day. Homes for the aged are operating anywhere from \$110 through \$118 per resident per day. Not included in that figure: Homes for the aged are not accountable for mortgages. The municipality picks up that cost. They are not accountable for municipal taxes, business and realty, they do not pay provincial sales tax and they get a 50% rebate on the goods and services tax, all of which we do not get. Those are all in addition to the \$118. That disparity is what caused Justice Holland to say that the situation has to be resolved. It has to be resolved quickly and there has to be some equity in the system for all long-term care facilities.

1530

Mr Villeneuve: How many nursing home residents would you have in your eight facilities?

Mr Fraser Wilson: We represent 654 residents.

Mr Villeneuve: You touched three times here on compliance and sanctions. Could you elaborate on that a little bit? Because Bill 101 will be addressing that very directly.

Mr Fraser Wilson: Sanctions, as I understand the proposal, would have an inspector or a compliance officer come into the facility. In the event that they find any non-compliance, they have the ability to literally stop your funding. If the funding stops, it puts the facility in a very awkward position in that it has a need to continue to get the revenues. In the event that the revenues are not forwarded by the ministry, then we would be forced into a predicament where we might have to cut costs. In order to cut costs, that is going to reflect directly on the residents.

Mr Villeneuve: Inspections are done regularly at the nursing homes, I gather. Could you explain what's happening now on-site in your eight nursing homes?

Mr Fraser Wilson: On an annualized basis every nursing home in Ontario is inspected. We call it an annual re-license. At that annual re-license they check our performance relative to compliance management, the standards established for nursing homes that we have to comply with. On the exit of that inspection they will either say that we are totally compliant or we are non-compliant. In the event that we are non-compliant, we have to propose our corrective action. That corrective action is then reviewed by the ministry and is seen as being acceptable or unacceptable. If it's unacceptable, we are given the opportunity to give a second corrective action. We'll go through that process a couple of times. Then it gets under enforcement, and that's where some of the more senior bureaucrats in the ministry are involved and take far more aggressive action.

Mr Villeneuve: Have you found it reasonable?

Mr Fraser Wilson: Absolutely.

Ms Carter: As the member for Peterborough, I'd especially like to welcome you to the hearings.

Mr Fraser Wilson: Thank you.

Ms Carter: You seem to imply that for-profit homes are going to be disadvantaged. I am a little surprised at that because it seems to me that this legislation is compensating for what was in fact a disadvantage in the past, that many homes had residents whose real level of care was not

being funded, whereas now, through the three different categories of funding—the residential cost, the levels-of-care funding and the programming money, which I gather will be on a per capita basis—it seems to me that all facilities will now be funded equally, the only difference being that if they have more high-level-of-care patients they will get more for that reason. Could you comment on that?

Mr Fraser Wilson: I don't believe I did allude that we would be disadvantaged. I cautioned that our past experience has been that where we are asked to perform at a specific level the funds have not been met by government. If the eventuality comes about that they hold true to their promise or their obligation and are accountable, then I certainly would not be disadvantaged, depending on how the dollars are distributed between the three categories you just alluded to. But that we don't know yet.

Ms Carter: Of course, there is a ceiling to the amount of money that the government has available, but on the other hand this is a larger sum than has previously been available, and although priority is going to be for heavy-care patients, there will not be extra people in that category because of the legislation, so I can't see that anybody's going to be worse off.

Mr Fraser Wilson: Until such time as we know where the dollars are going to go, in the nursing and personal care aspect of the funding model we estimate the cost for nursing homes as \$46 per resident per day for providing nursing and personal care services. If this new funding model comes out and allocates \$35 per resident per day, then we are absolutely going to be disadvantaged. It will have a direct impact on the number of staff we can have on hand. To say that we're going to be disadvantaged—we can't comment until such time as we know what the funding model is going to be.

Ms Carter: Maybe we need some clarification. I don't know whether I can do this.

The Acting Chair: The parliamentary assistant has been asked to speak. Maybe this is his chance.

Ms Carter: The \$35 will be what the residents pay; it will not be the total funding.

Mr Fraser Wilson: That was just an example.

Mr Wessenger: I wanted to make a few comments. I just want to reiterate what Ms Carter has indicated. The fact is that this legislation has priority with the government, because of our recognition of the inequitable funding for nursing homes and many homes for the aged. As you may know, in 1992 we did provide two sets of bridge funding in addition to the economic increase to nursing homes to respond to the difficulties. The whole level-of-funding approach is to create the equality and to provide those services. I know everyone is waiting to see what the end result is going to be, but there is going to be \$206 million to distribute to the homes for the aged and nursing homes, which is bound to have some impact on improving services in those areas.

Mr Fraser Wilson: Just to comment on the point you made about the funds we received in 1992. Albeit we received funding, it equated to 2%. It is no secret that

going through labour negotiations, which accounts for anywhere from 65% to 75% of our revenues, the average increase was in excess of 5%, so 2% didn't begin to look at it. That's where we're very apprehensive about the commitment from the government in the future. We need to know that they are going to recognize our costs.

Nursing homes are probably the only private sector in our economy that has to publicly disclose a financial operations statement that indicates exactly where our dollars have been spent. Those are submitted to the Ministry of Health and, to be quite frank with you, have not been given due consideration in the past. That has led us to be very apprehensive. We would like something in the proposed legislation that would actually deal with that, make sure there's an obligation on them to look at the costs of operating a nursing home, staffing a nursing home.

Mrs Caplan: This particular piece of legislation, I believe, really turns the clock back from the compliance model which is in place right now at the ministry to an outmoded, outdated inspection model that does not improve quality of care or quality of life to the residents of the facilities. The existing Nursing Homes Act has not been amended to reflect the change. The change in the new compliance plan has been the result of policy decisions. There is an opportunity in this legislation to update as opposed to turn the clock back. The language and tone of this bill, which really replaces it with an adversarial model, are ones that I think we have a chance to look at changing.

Over the last few days of these hearings, I've been exploring some different alternatives. One that we've been talking a little bit about would require a residents' council, which this legislation does not require but which the Nursing Homes Act does require for nursing homes. Have you had good experience with residents' councils in your home? Do you find them active? Do they make a difference?

Mr Fraser Wilson: For the most part, very active. On occasion, depending on your resident population, you may have trouble filling the capacity, but for the most part it's very insightful as to how they view their living environment.

1540

Mrs Caplan: Do most of your homes have total quality management processes?

Mr Fraser Wilson: We have quality assurance. Quality management is a new concept that's being introduced by accreditation. We are pursuing that avenue, but we most certainly have quality assurance in place.

Mrs Caplan: You're quite correct that the term "quality management" is new and that it is part of the accreditation process. Do all of your homes participate in accreditation?

Mr Fraser Wilson: Yes, every one of our facilities has a three-year accreditation status.

Mrs Caplan: Would you be comfortable if you had a model which replaced the inspection model and allowed for a compliance management approach where, rather than inspectors, you had compliance officers, if accreditation on both management and outcome were mandatory as opposed to voluntary, as it is now?

Mr Fraser Wilson: If we look at compliance management, it has spun off from accreditation.

Mrs Caplan: That's right.

Mr Fraser Wilson: Accreditation has actually established criteria, standards etc throughout Canada. I believe compliance management has actually adopted a lot of the philosophical goals, standards etc. To be quite honest with you, we already abide by that kind of standard and find it a very good model. It's very reflective of the ability of care and how you might equate yourself to another long-term care facility. We find it a very effective tool.

Mrs Caplan: The other thing that accreditation does is the concept of peer review, where the assessors and the surveyors are there to come in on an ongoing basis. Are you comfortable with that concept of peer review as one of improving quality?

Mr Fraser Wilson: I'm not quite familiar with peer review, to be quite honest with you.

Mrs Caplan: That's where assessors come from the same kind of facility. They come in to help and to assess what you're doing.

Mr Fraser Wilson: To put it in the context of Ontario, as opposed to accreditation, which brings somebody from Alberta or someone out from the east, where they have completely different funding circumstances and different levels of care—it's hard to equate to them sometimes—I think it certainly would not be detrimental to have it internal to Ontario, especially where everybody is having to abide by the same legislation, be it homes for the aged, charitable homes or nursing homes.

Mrs Caplan: One last, short question? **The Acting Chair:** All right, a last one.

Mrs Caplan: Would you support an amendment that allowed for a right to refuse on the basis that the long-term care facility could not provide appropriate care, provided that there was a right of appeal by either the placement coordination service or the client?

Mr Fraser Wilson: I think it's necessary.

Mrs Caplan: Do you think there should be an exemption from that right of refusal in emergency situations, for the short term?

Mr Fraser Wilson: Ultimately we're going to have to work with it somehow. As long as it's short-term and the efforts are being made by the placement coordination agency, the Ministry of Health and the actual facility, I don't—it has to happen; somebody has to accommodate the resident. They can't be abandoned.

The Acting Chair: Thank you very much for coming before us this afternoon. We appreciate your time.

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

The Acting Chair: And now the familiar Haliburton, Kawartha, Pine Ridge District Health Unit—familiar to me, at least, and possibly too to Ms Carter. Welcome, gentlemen, old friend Mr Wensley and new man on the block, Dr Hukowich. I'll ask you to identify yourselves

and make your presentation at this time. Welcome to the committee.

Mr Bill Wensley: Thank you, Madam Chair. We're grateful for this opportunity. I'm Bill Wensley, a member of the board of the Haliburton, Kawartha, Pine Ridge District Health Unit. With me is my colleague, Dr Alex Hukowich, who is our fairly recently appointed medical officer of health.

I would just like to take this opportunity to explain briefly who we are and what we've been doing. I believe you have copies of our presentation. I think perhaps I will read most of it. It shouldn't take too long.

The Haliburton, Kawartha, Pine Ridge District Health Unit is one of 43 health units, regional and municipal health departments established and operating under the Health Protection and Promotion Act. For almost 20 years we have been responsible for the ongoing administration of the provincial home care program in the counties of Haliburton, Victoria and Northumberland. Over the years, as the mandate of the home care program has grown from solely acute services to include the chronic home care program, the integrated homemaker program and the school health support services program, the board of health has been charged with the responsibility of its administration.

The term "administration" is perhaps an unfortunate one. It does not do justice in describing the health unit's role in ensuring the availability of the various component services. Our involvement has made these programs more than a legislative description, but a tangible and real service enabling people to receive appropriate care and continue living in their own homes. The health unit therefore provides not only an administrative support structure to ensure that budgets are drafted and bills are paid, but provides the case managers and coordinators to assess the needs of the clients, arrange the required services and monitor the client's situation.

We recognize that while some do not accept this brokerage model, the existence of independent case managers very much parallels the independence foreseen for the placement coordinators and is central to a balanced system that is responsive to clients' needs but neither solely client-nor provider-driven.

Although not all home care programs are provided through health units, the board feels strongly that where this has been the situation, health units have fulfilled their obligations in the operations of the programs and should continue to play a central and key role as any legitimate problems in the system are addressed by building on existing strengths. I believe this is one of our fundamental underlying philosophies to this whole issue.

We do support the government's five stated major policy goals of equitable and needs-based funding; strengthened accountability; consistent facility payment; single point of access; and, flexibility to allow direct payment for self-managed care for the disabled. We support these.

The board has in the past supported the underlying principles related to long-term care reform and we have only raised concerns where government plans for the translation of those principles into structures and organizations have been unstated, unclear or felt to be inefficient, duplicative or without evidence that they would indeed accomplish the stated intent. As an example, we opposed the establishment of the 40 new service coordinating agencies, as proposed in the October 1991 government redirection discussion paper.

At this committee's initial briefing by the then Minister of Health, the Honourable Frances Lankin stated that Bill 101 was, "the beginning of a reform process that will result in a major restructuring of long-term care and support services for elderly persons, adults with physical disabilities and people who need health services at home."

The minister also recognized that this bill does not address many of the vital issues relating to what the long-term care system will look like at the completion of the reform process or at any intermediate steps in this process. We would have preferred that the government's intent was as clearly enunciated as its underlying principles so that this bill, any subsequent legislation or any organizational changes could be reviewed in the context of a specific blueprint or road-map. Only in this way could there be informed discussion as to whether both legislative and non-legislative proposals for change could indeed produce an agreed upon desired end. This is one of our major concerns.

The board does not feel in a position to comment specifically on the various technical issues raised in this bill. However, we believe the bill creates the pivotal position of placement coordinator in a way that may obviate the main need for any further legislative changes. It is our understanding that not all structural elements require a legislative framework. While hospitals, health units and long-term care facilities do have empowering legislation, health councils have been set up without recourse to legislation.

If placement coordinators can be either persons or entities, will there necessarily be any requirement for further legislative amendments or new legislation to resolve the remaining issues, or can the government simply designate Ministry of Health employees, existing organizations or create new organizations to serve this function without the necessity of further discussion or debate in the Legislature?

1550

The board is concerned that what is presented as merely a beginning to the reform process could become the end of any required legislative change. We would like the assurance that there will be further opportunities to discuss future steps in the reform process from the perspective of how they will meet the underlying principles of reform.

I now come to our main recommendation. We believe that the key role of placement coordinators should not be enshrined in legislation until such time as the government has spelled out the model or models which can be used for the governance and coordination of long-term care, as we believe these are equally crucial steps in the reform process. To that end, we support the minister's intent of calling a further conference on long-term care once the government's special adviser's report is released. We also support the role that district health councils can play in local planning and implementation of long-term care services.

If the long-term care reform process is to eventually lead to an improved system rather than simply a different system, it is important that proposals at various steps of the process be examined within the framework of the desired outcome. None of us can judge the value of any particular path in this journey, unless we know the desired destination.

We thank you for this opportunity to express our views in a general way on this bill.

The Acting Chair: Thank you very much and I'm glad that you have left time for questioning. I believe the government side is first in the questioners. Do I have someone who would like to pose a question? None? Then, Ms O'Neill.

Mrs O'Neill: As we've said before, every brief has a different perspective, and I'm not sure we've had a health unit before us to this point.

I want you to tell us a little bit more about how the district health council is working with this piece of legislation, because we understood that the minister in December said, "Let's get busy out there in the field". Can you update us on where you are in Kingston at the district health council level with this piece of legislation?

Interjection.

Mrs O'Neill: I'm sorry, Peterborough.

Dr Alex Hukowich: Haliburton, Kawartha, Pine Ridge, which are the three counties that surround Peterborough—

Mrs O'Neill: Thank you, help me.

Dr Hukowich: —although the health council for that area does include the four counties, and so includes Peterborough. The health council, as opposed to the health unit, has set up a number of committees and those committees, I believe, are still working on trying to develop some kind of model that may be appropriate locally.

Mrs O'Neill: And would you be part of that?

Dr Hukowich: The health unit has been part of some of those committees, yes.

Mrs O'Neill: You seem to be expressing very strong cautions regarding the placement coordinator, I think maybe the strongest we've heard, particularly in suggesting that we remove the clause from the bill totally until the models have been determined. We've heard all kinds of fears. I think is the best word to use regarding the placement coordination. I think you've worded it so well when you say that we don't know whether it's a person or an agency, and we've been told various things, particularly by the parliamentary assistant, throughout the hearings, but the bill itself does not say very much. Particularly in areas where there have not been firmly embodied boards and placement coordination agencies, there are certainly a lot more concerns. Do you want to say a little bit about what you would find as necessary in the model, how complete it would have to be, or some of the guidelines?

In London, we actually had a group present to us a model or set of guidelines it felt should be right in the legislation. I think we know, but maybe you could emphasize a little more why you are so cautious, and then what you think are the necessary ingredients for your ease in accepting the role.

Dr Hukowich: I think the reason for the caution is because—again, we may be in error—certainly our understanding is that you don't necessarily have to put everything into legislation. I think the district health councils are an example. They're provided no kind of legislative mandate yet they're there and they do their work. So the concern is that you can also develop, without any further recourse to legislation, a variety of policy decisions, a variety of models, some of which may be appropriate, others may not be, without any further opportunity for discussion in terms of whether they will meet the stated intent of producing an improved system.

In terms of what we would like to see in those models, I don't think the board is committed to any particular model. What we'd like to see is what's being planned or what the range of options may be as they're developed locally, so that we would know that they're going to meet the intent of the legislation in meeting those underlying goals.

Without the government coming forward, we're left with a variety of previous statements that have been made in previous documents setting up new agencies, which we feel is clearly inappropriate, would be a waste of effort, would be a waste of money at a time when the funds should be put into actual service provision rather than developing new agencies. We'd like to know the plans in terms of those other areas first, so that they can form the context for these placement coordinators, whether they be persons or whether they be agencies.

Mrs O'Neill: As I say, I think you have expressed very clearly what many other people have brought forward as well, and I hope that the government is hearing, because there is a giant leap of faith into a whole body of regulations which we would not have any access to or any ability to comment on, nor you, and that certainly would be part of our concerns as we go into amendments. I think that our party wants to tighten that up or give much more direction to what the role of the placement coordinator would be, who or what agency, and guidelines that would surround it. We've come to that conclusion as we've travelled across the province.

So you've brought it and highlighted it, and I think there must be other things in the bill that are also of concern to you but you've decided to highlight that one, and I'm very pleased you have.

The Acting Chair: I believe the parliamentary assistant, Mr Wessenger, would like to comment.

Mr Wessenger: Yes. I gather you don't have placement coordination in your area now?

Dr Hukowich: I'm not certain of that. As I say, I'm relatively new there. I've come from an area where in fact we did have placement coordination, as operated by the health unit, along with the home care program and the various other programs. I'm not certain as to what the exact situation is in Haliburton.

Mr Wessenger: Perhaps I should give some indication. As you know, about half the province is now presently covered by placement coordination, and I must say that every place we've been to where they've had placement coordination we've heard very strong support for the service.

Basically, once the legislation is passed, existing placement coordination agencies will continue to fulfil that function. There is an intention to extend placement coordination across the province to areas that don't have it, but there was a definite statement made that there would not be a new bureaucracy created.

Under the former process, something called SCAs were proposed, which was an independent separate function, but that is not the case. The intention is to attach placement coordination, where it doesn't exist, to existing agencies rather than to create a new structure. The eventual process is to go through the creation of what they call the multiservice agency through the district health councils' planning process under the long-term care subcommittee. In fact, the whole planning process for the long-term care is to be through this long-term care subcommittee of the district health council, which is to be broadened to have broader consumer input, as well as provider input and so forth.

So that's sort of the perspective. That's what I was somewhat concerned about why you would be concerned about having placement coordinators put in legislation, because, quite frankly, I don't see how we could achieve the models of having those with the greatest need being given the highest priority for placement without having placement coordinators in place, as well as we couldn't provide the consumer choice to bring all those facilities to the consumer, which is a very important element of the process.

1600

Mr Wensley: I would just like to emphasize that we don't disagree with the idea or the concept of placement coordinators. We just don't feel it's necessary to put it in legislation. We're not convinced that's necessary.

Dr Hukowich: At least until the remainder of the information is available as to how they're going to work and how it's going to be governed.

The Acting Chair: I'd like to thank you very much for coming before the committee. I wish we had more time, because I know there are other questions, but we must move on.

Mrs Caplan: Chair, could I just make one small statement? The long-term care reform policy document framework: We've had a commitment from the parliamentary assistant that that should be available in March. Also in March should be the chronic care rules study from them. Given the legislative process, I'm asking if it will give you comfort having that before this is passed?

Dr Hukowich: I think if we can have all of that and everyone can look at that and debate whatever comes out in that document, then yes.

The Acting Chair: Thank you very much.

FAIRHAVEN HOME FOR SENIOR CITIZENS

The Acting Chair: Fairhaven Home for Senior Citizens, welcome to the committee. Would you kindly identify yourself, please.

Mrs Dawn Straka: I'm Dawn Straka. I'm the administrator at Fairhaven Home in Peterborough. I do apologize. A committee management member was supposed to

come along with me, as was an advisory committee member. One got busy today advising and the other got busy doing political things, so I'm here alone.

Mrs Caplan: Political things?

Mr Villeneuve: We're not used to that.
Mrs Straka: You're not used to it, okay.

At the beginning I'd just like to say a few words about Fairhaven. We are a joint city-county-municipal home for the aged. We're situated in Peterborough but serve the whole of the county of Peterborough. We have 132 residential care beds, and approximately two thirds of those residents have extended care approvals, but we can't honour them because we don't have the extended care beds to put them in. As well, we have 121 extended care residents.

I did, on my handout, show the actual costs for 1992. I thought this might be helpful, that the actual residential care cost last year was \$59.28; extended care, \$117.03, and when you average them out, divided by the number of resident care days, it comes out to be \$89.41.

The new directions in the long-term care sector of Ontario's health and social services system certainly received strong endorsement by the home prior to and during the discussions and consultation, and certainly many of the principles of the redirection reform were endorsed strongly in those I've listed.

What I'm attempting to do today is not address everything that the other—I know our association and my colleagues in other homes have come and talked about a number of issues. What I've done is picked out a few issues that may be of less importance but certainly might help clarify some of the thinking regarding the institutional sector.

The first issue is governance. Municipal homes for the aged, as I'm sure most of you know, are governed by political appointees. In my particular case, they're all municipal or county politicians. Many homes advocate a change in this practice and certainly I know I would welcome a broader mix of board members with a wide variety of expertise.

All new initiatives in the past four years in Fairhaven Home have used a community advisory committee with representations of residents, families, concerned citizens and professional experts. Examples of such advisory committees are a pastoral care committee or our special care and our fund-raising committees. We certainly strongly appreciate the value of the advice, and we advocate this practice continuing.

Talking about governance, certainly some of us have sat in Toronto the last couple of days at a large meeting with members of the government looking at Bill 101 and what the meaning is going to be for us. I think one issue that we're all still questioning, and that I realize will be addressed down the road in 1994 and 1995, is the role of municipalities. Another issue related to this is the importance, certainly, that education is going to have for all of us and particularly, I would assume, for the private sector, for the directors and owners, and in our sector for the municipal representatives, to learn more about what is expected of us in the near future.

Related to the issue of governance is accountability, and certainly we believe municipal homes are and have been accountable. We are accountable not only to our municipal representatives and city and county bureaucracy but to the political government through our long-term care area office, as well as, obviously, to the community through our residents, our families, auditors, accreditors. As a public institution, we've been—I was going to say "subjected"; that's not quite the right word—but we've had a twice-annual public inspection panel come through our home. This is a panel of jurors who have a couple of weeks off, and they do come and visit all public institutions, so we've experienced that.

"Quality services" is a term that our home has coined for what most people are calling total quality management. There are other terms for a similar concept. Though our program is still in its infancy, everyone from the committee of management to the line staff and residents will be involved. One strategy that we are using is a suggestion with formal feedback to suggestions. Any suggestion that comes through to us, we put the response up for everybody to read and share it with everybody in the home. We've also been trying brown bag lunches around the clock with staff, and this is just so that we get information feeding up and down through the channels.

You questioned the gentleman from Omni regarding residents' councils. Certainly our residents council is active, but with the level of client or resident that we're now getting, it's often very difficult. They're just beyond being capable of active participation. But we certainly do have meetings on a very regular basis.

The other thought that certainly we will be having is a family council. We've done a lot of family support work in the home, but I believe in the future having a family and significant-other council is important.

Having a new set of standards dedicated to long-term facilities is certainly most welcome. For our sector, a revision of the very outdated Ministry of Community and Social Services administration manual is very welcome. We certainly are pleased that we're getting new standards. At the same time, we caution against the possibility of putting more emphasis on the process of meeting defined standards than on actually improving the quality of the programs and services. I can cite some examples. Certain facilities might have beautiful policy and procedure manuals, but if they don't apply, then they are of no use. So that's just a caution.

1610

The policing approach: There's some indication that certainly for the municipal and charitable homes there will be more inspection than we've had in the past, and we caution against the policing approach because we believe it inhibits professionalism and certainly takes power away from boards and staff.

I thought a word on volunteers might be useful. They certainly play an important role in our facility, from the board and committee participation to resident programming, entertainment, to special projects like Canada 125 celebrations and outreach programs like Meals on Wheels. We have hundreds of volunteers in our home every week. They're recruited locally and come to the home with a

desire to do a specific program and service. They don't come just because they want to be near seniors or whatever. They want to do something very specific. Volunteers not only input into the running of our facility, but they are another strong link between the facility and the community.

Respite or short-term facility care of persons who normally live in their own homes needs to be addressed in administrative policy and procedure, which hopefully will clarify the ministry's expectations. This is something we've been waiting for for a number of years.

On March 8 of this year, my home will open a second special care unit, with 17 long-term beds and six short-term beds. I probably should just quickly review what special care is. This is a unit dedicated to persons with cognitive impairment, and at the end of the unit there is a locked door that one must know how to key to get in and out of.

This unit will occupy redeveloped residential care space. I think this is something that homes that were predominantly residential care originally—the space is no longer appropriate so what we've done is, on our own, with very little ministry financial support, taken the space, redeveloped it, and we will use it for this care.

The long-term care area office has given us approval for the long-term part of this proposal but not the six shorter-term beds, and I certainly urge this committee to try to address short-term care, because it is a need, definitely.

We did a survey back in November in the planning of this facility and there were 59 people in the Peterborough area who were needing to get into that 23-bed unit at that time.

Pre-admission assessment: In the last year the ministries of Health and Community and Social Services, as you know well, and all long-term facilities invested a tremendous amount of effort into comprehensive resident assessment and documentation. The new draft standards resulting from redirection have proposed utilization of a request-for-admission form which is not consistent in format and terminology with a classification tool. That was the tool that we all used in the fall.

Other consistent forms exist, and certainly we're advocating the one that our PC has developed, which is the Peterborough assessment for continuing care coordination. It is an excellent form and it is consistent with classification. My suggestion is, it certainly makes it a lot easier and more objective when terminology is the same. So please, if that can happen, that would be great.

In conclusion then, on behalf of our residents, families, board staff and volunteers, I've raised some issues. Although these are not as high-profile as funding, inspection, centralized sanctions, control and placement coordination, attention to these issues I've raised will also make a difference for persons requiring long-term care in facilities like mine. Thank you for this opportunity, and if there are any questions, I'd be happy to try to answer them.

The Acting Chair: Thank you very much for coming. I believe there is time for one question per caucus. We'll start with Ms O'Neill.

Mrs O'Neill: Two things you mentioned have not been very much part of our discussions. I would like to

have you say a little more about them, because you seem to indicate that there are needs and that the approvals haven't been coming. Before I begin to do that, you pricked my curiosity with your brown-bag lunches around the clock with staff. I don't know what that is; it sounds interesting.

Mrs Straka: Basically, as senior staff within the home, we come in and sit down and talk to the staff who are on duty about any issue they're concerned about. They're very concerned about funding, for example. They hear, "We get so much," or that the ministry in the future is only going to be giving \$37, or I think it's up to \$38.25 now; that's what I heard yesterday, I believe. It's to try to clarify this for them. As well with the residents: We wander around the home and try to sit with them and listen to what their concerns are.

Mrs O'Neill: That sounds like a very good initiative. If I may go back to the two parts of your brief—they're actually on the last page. You're talking about respite. I'd like you to talk a little bit about who really needs that, how important it is in your community of Peterborough, and then the six short-term beds that you say are so high-profile in need in your community and yet have not received approval. I think it's important that we hear.

Mrs Straka: Who are these people? These are people with cognitive impairment, probably Alzheimer's, but as you well know, one cannot really definitively diagnose Alzheimer's until the time of autopsy. But they're people who are confused, whose needs have really outlived the community services; they may require constant supervision, and whose families may be burnt out. You may have noticed that I am on the board of the VON. I certainly wear the two hats. That's my volunteer board; this is my professionally paid. Anyhow, they're people who used to go to the VON day care centre, but that no longer is enough to meet their needs, so they come in.

Mrs O'Neill: So the short-term?

Mrs Straka: That's the overall. The short-term side is people whose families need a break. I know the legislation is looking towards giving people 30-day stays in institutions like ours, up to three times a year, but it's to get the approval from the local office to proceed with this.

Mrs O'Neill: Thank you for highlighting those special needs for us.

Mr Villeneuve: Thank you very much for your presentation, shedding light on some of the areas that maybe haven't been touched on quite so much. Volunteerism is very important in your operation. Would you have a waiting list?

Mrs Straka: We work through the Peterborough continuing care coordination service. They maintain the waiting list for us. For example, in the last few weeks, we've had to hold back on admitting residential care residents to let our population drop down so we can admit these new special-care people. We've seen lists there. You could have up to 50 or 60. How they divide them is according to their level of need. They may be residential. They also list them according to where the person is, whether

they're in hospital or another facility, whether they're at home on their own.

Mr Villeneuve: That's my next question: Is it domiciliary homes, rest homes, or are people basically coming in from their home or that of someone of their family? Would you have a breakdown?

Mrs Straka: Yes, I have a sense of where people are coming from into my institution. I'd say about a third of them are coming from other facilities; probably most of that one third is from hospital directly. A crisis has happened in home, and they need to be institutionalized quickly. In Ontario we've developed a number of rest homes and retirement homes which have, in many cases, lovely facilities but not a great deal of supportive staffing to go along with it. It's these people who are now coming or wanting to come to homes for the aged, and I'm sure nursing homes as well.

1620

Mr Villeneuve: So that would indicate why your high percentage of extended care requirements; it's a little higher than normal.

Mrs Straka: We're one of the institutions in the province that has a lower ratio of extended care to residential care residents. Many of the homes for the aged are as high as 80%, 90% extended care. That has depended upon many factors in the past.

Mr Wessenger: Thank you very much for your presentation. I'm pleased to see that you've anticipated the legislation with respect to the respite care plans.

Mrs Straka: Yes, we've tried to learn what's coming.

Mr Wessenger: I really appreciate that; I think you're doing a great job in that area. I'd just like to assure you, though, with respect to your comments concerning the inspection process, that under the present inspection process or compliance or program adviser system, the same people are going to be doing the same thing they always have done and be carrying out the same policies. I just wanted to assure you of that.

Ms Carter: I wanted to say something on the same point. Welcome to the hearings. Of course, I know Fairhaven home very well. What I know particularly about Fairhaven is how open to the community it is; it is a community facility. Municipal politicians take a great interest in it and, as you said, there's a large number of volunteers and there's a lot of coming and going. Fairhaven is very open to the community. Even if you wanted to get away with anything, you couldn't, because there is all this coming and going, and it's so much part of the community.

When you say you don't want intensified inspection because it inhibits professionalism and power to boards and staff and so on, that may very well be true of Fairhaven, which doesn't need that, but I think you were here this morning when I—

Mrs Straka: No, I was not here this morning. Sorry, Jenny.

Ms Carter: There was one gentleman here who agreed that although most homes are very well run, there

are some he personally would not want to live in. In other words, there are problems in some facilities. I just wondered whether you would agree that we do need some kind of system in place other than the more general safeguards that maybe apply in Fairhaven.

Mrs Straka: Over the years, we've had a fairly good relationship with the local Comsoc office, now the long-term care area office. I believe they're very aware of the standards of care within our facilities. I'm personally not upset about having an inspector or compliance officer come into the home; I just don't want to spend tons and tons of time preparing for this and taking it away from the other duties or tasks that would ultimately maybe benefit our residents to a greater degree.

The Acting Chair: Thank you very much. I really appreciate you coming to the committee. I wish you well.

Mrs Straka: Thank you.

SPECIALTY CARE INC.

The Acting Chair: Would the representatives of Specialty Care Inc please come forward.

Ms Paula C. Jourdain: Good afternoon. I'm Paula Jourdain; I'm general manager with Specialty Care. This is Mary Gorham, who was the administrator of Franklin Lake Manor, an old facility that's since been replaced and is now operating as Trillium Ridge, which has been open since May in Kingston.

Specialty Care is a family-owned corporation. We own four homes across the province, nursing homes and retirement homes. We've just built, as I mentioned, Trillium Ridge in Kingston, which has been open for six months. It's a combination facility: 90 nursing home beds and 44 units of retirement home. I really want to address the committee based on our experience here in Kingston. I know you've been inundated with nursing home presentations this morning, so I won't go through the full report—that is, the common things we've been hearing from other people—but try to highlight our experience as it relates here to Kingston.

First of all, we're looking forward enormously to seeing long-term care reform come into place. Since 1972, we've seen the differential in funding between nursing homes and homes for the aged increase dramatically, to the point where municipal homes for the aged are now receiving close to 40% more than nursing homes. The situation has just become unbearable, and we look forward to having the funding system equalized so that we have the opportunity to provide the same level of care that the homes for the aged have been able to provide.

We also look forward to an equalization in the inspection process, as was just talked about. We've certainly had a great deal of experience with the inspection-compliance program, and we've seen it evolve from the days of the "police" model to a more consultative report. I know that the government's own Woods Gordon study that was commissioned in the late 1970s, I believe, or early 1980s—

Mrs Caplan: It was 1986.

Ms Jourdain: —thank you; 1986—supported the fact that a consultative model was preferred to a police model.

I certainly know, as a board member of the nursing home association, that nursing homes across the province are committed to providing quality care. We've been operating with such small margins and in such deficit positions that problems have arisen, and I think that that is always the case. Once the funding is equalized, I think you'll find that services across the board will improve and problems will decrease

As a matter of fact, the nursing home association is just preparing a report on accreditation. As you may know, the nursing home association has been strongly in favour of accreditation, and at the present time over 95% of our members are accredited. We would hope that the accreditation system, which is a national system, could be a beginning to a self-monitoring peer review. Where now the Ministry of Health has the compliance management section, plus what's called the enforcement section for sort of problem homes or new homes, perhaps over time the compliance section could be reduced in its need, in that only if there are certain particular problems, then you could go to enforcement; if you were new or if there were certain problem identified. Hopefully, we could move through accreditation and through other systems to selfmonitoring. The legislation seems to be based more on the old inspection system, and we'd like to see that some thought be given to growth in the self-monitoring area.

Another of the key points we wanted to address was the whole role of placement coordination. In Kingston in particular, I think, we have an excellent placement coordination system that's already working, and working very well. We'd certainly like to see that existing program with the home care system. I know it'll be different in different communities, but here we'd hope that would be the program that would be identified to carry on and that no new level—I heard you talking a little bit earlier—of bureaucracy be created. I think we all know there's not enough funds around to create more bureaucrats.

I think it's fundamental that we do have a key access point for seniors, whether it be for home care or whether it be for institutional placement or short-term placement. However, I don't think it's necessary for us to have one agency provide all the services. I know there's been some move to coordinate all of the home care stuff. Obviously, in the institutional, it wouldn't be all one provider. But as long as there's a good access point, that people know where to go, it does allow the community to develop different alternatives that meet the needs of different ethnic groups or different preferences in terms of delivery service. I certainly would hope that in terms of the home care that the for-profit and the public could still coincide to allow diversity in services.

The other thing we would like is to make sure that choice is still allowed for the consumer. There seems to be an appeal mechanism built in for the consumer with regard to the decision as to whether they're eligible for placement or not, but there doesn't seem to be an appeal mechanism built in for the actual placement that's recommended.

At the same time, there doesn't seem to be any ability for a home to decide who it will accept and will not accept. I can understand that there's a concern that homes may take all the "light-care" people, and obviously that's not the intent. But I think a home should have the ability to define its mission and to say which kind of clients it would like to take. Trillium Ridge, as I said, is a joint facility. I know Ernie Lightman came out with some recommendations suggesting that combined facilities were not advisable. I would like to strongly, strongly emphasize that we have found that combined facilities are just so appreciated by the community.

We have a number of family members in our Keswick home—not in Kingston as of yet—where you might have two people come into the retirement home and then, as one person requires more care, he or she may move to the nursing home. Having a combined facility, you're under the same roof, you have the same management, you have the same staff, the couple can still enjoy their meals together. It just provides an awful lot of services and it means that people don't have to move two and three times. I just fundamentally disagree with Mr Lightman in that particular regard.

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I guess it comes up here. In terms of Trillium Ridge, in our nursing home side, we do give preference to our retirement home residents. Some people say this is favouritism, but we feel that it's a community. We've accepted people into this community, and by giving them preference, we're guaranteeing them a safe haven. They come into a retirement home which is a little bit nicer. There's more carpeting. It's private pay. People are paying a little bit higher. They want to have extra services and they get them. They get larger rooms. Maybe they'll get two rooms. The residents in the retirement homes are more active, so you have more bridge clubs and euchre clubs which you don't have in the nursing homes. It's a way to move into a communal setting at a time when you can accept it and you can enjoy it, so that when you do go to a nursing home, it's not a huge shift.

We found that families have really appreciated that, and I would like that to be considered. I would think that is a mandate nursing homes should be allowed to define for themselves, as well as things like, obviously, the ethnic homes, the Chinese homes, the Ukrainian homes, whatever. I think that's a lot more clear-cut. Certainly this could be subject to abuses, but with some guidelines of placement coordination service, I think homes should be allowed to set their mandate which would be approved as part of your service agreement.

Sanctions: Again, in the legislation it sounds like there's a huge hammering. I can appreciate that the government wants to have some controls. It's just that when you read them in black and white, it sounds pretty onerous and it sounds like you can put us out of business in a day. I would just caution that they sound pretty strict and would like to see some sort of recognition that these would be last-resort activities.

I think you've heard all the other things before from a nursing home association or from the other members, so Γ d just like to open it for questions now if anybody has anything.

The Acting Chair: Thank you very much for your presentation. We'll begin with Mr Villeneuve.

Mr Villeneuve: Thank you for your presentation. You just touched on compliance. Have you had any problems meeting the requirements? The nursing home's been there for 15 years?

Ms Jourdain: We've operated nursing homes for 15 years; Franklin Lake, yes.

Mr Villeneuve: Any problem in that area?

Ms Jourdain: We've had some problems but not major problems. I think we went through a hard time in the early 1980s when there was this sort of—they called themselves, "We're here to police you." That was used, and there was a "let's see if we can find some problems" attitude. I think in the last three years the approach has been much more consultative and we don't have problems now. I think that works much better. I think the compliance advisers—I'm still calling them inspectors; I'm showing my age and my disability to change—often do provide assistance. There's good and there's bad, as within every pot, but quite truthfully, if there's a problem inspector, you can get it resolved at head office. But no, it's not a problem.

Mr Villeneuve: You have, of course, your groups of residents who belong to the residents' association. Is that working reasonably well and is there involvement by the families?

Ms Jourdain: Yes. We have regular family meetings. In one particular home, we've started a residents' advisory council or family advisory council, and we've had several family meetings at Trillium Ridge, although we haven't formed a council as yet.

Mr Villeneuve: Informally, that is resolving the problems to your satisfaction, the satisfaction of the residents and the families, and you say don't bring us into it.

Ms Jourdain: Actually, as you increase the copayment and people have a greater say in what they're purchasing, I think you're going to find them becoming more vocal and saying, "I'm paying for this; this is what I expect". Yes, I think that's very true.

Mr Owens: Just a quick question to the parliamentary assistant. The presenters have raised again the issue around an appeal mechanism for homes and residences. My question is, if we were entertaining an amendment like that—for instance, we currently have an appeal mechanism in place for potential residents. What would happen if an acute care institution was wanting to devolve a patient into the system, but an appeal has been filed by the resident or by the potential receiver? What protections would the ministry be entertaining in terms of the user fees that are available to the hospitals now? Once a discharge date is set and if the patient isn't out by such and such a date, what kinds of things would the ministry be looking at to ensure that the patient's rights were protected?

Mr Wessenger: I think you raise an interesting problem with respect to what you do with the patient in those circumstances under the new legislation. Right now, of course, there's no real remedy except on a cooperative basis, but even under the new legislation, although a placement coordinator could select a facility on an emergency basis to send the resident to—because the highest priority

will be given to the cases that fall into the emergency category—if the home, on the grounds that will be under the regulations, takes the position, "We refuse this client because we do not have the services for this client," then that obviously creates an unresolved situation. At the present time, there's really no quick resolution to that other than to find another facility.

Mr Owens: Not to put you and the minister on the spot, but in terms of thinking the appeal process through, it's a concern that I've developed over the last week in terms of wanting to keep the patients' and potential residents' civil rights whole, so that they're not being penalized on one end while actuating rights on the other end. I certainly hope some thought would be put into that.

Mr Wessenger: I think the obligation of the placement coordinator would be to find a place quickly if he or she could under those circumstances. If one institution refused, you'd have to go to another facility, hopefully one that would accept. That would be the way it would have to work in practice. You couldn't really wait on an appeal. I think it's essential there be a quick way of trying to resolve matters before they go to an appeal. I think it's very important that you have some sort of dispute resolution process, some local way of dealing with it. Hopefully that would deal with most of the cases very quickly and not necessitate going to the appeal board.

Mrs Caplan: We've been exploring different models for ensuring continuous quality improvement and the new quality management concepts. Over the course of the last few days, we've talked about mandatory accreditation as opposed to voluntary, or as part of the contract that could be developed, that it would require accreditation, a quality management program, residents' councils, client surveys, peer review. It could be flexible and negotiated as part of the contract.

One of the thoughts I've just had, actually from talking with the previous presenter, was that since I believe the policy framework will look at devolution to regional boards for long-term care—that's what was originally intended and I'm assuming that's the direction this government intends to go—do you see a role for that kind of assurance back to that local body rather than to the ministry for the positive role of education, peer review within the district and that sort of thing, to help nursing homes, to help all long-term care facilities improve the quality of care, and reserve for the ministry only the opportunity to intervene when it has a real concern that patient care is in jeopardy, as it can in the Public Hospitals Act? To devolve the responsibility to the multipurpose regional body—

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Ms Jourdain: Yes, I would agree with that. I think that's why the legislation, the way it's proposed, with all this stuff about quality assurance, which of course is an outdated term as it is—I think if we go in with the belief that everyone wants to provide good service, that's a fundamental thing. We're going in; we want to provide good service.

If there's a bad service that's provided, whether because of poor management, lack of funds, staffing problems, labour problems or whatever, then I think, yes, keep your enforcement section downtown, but let's look at something, whether it be accreditation, whether it be through a combination of the two associations. The homes for the aged and the nursing homes are starting to communicate a little bit more closely and we see we will have to communicate even more.

Certainly, the Ontario Nursing Home Association has a set of standards for all our staff—for housekeeping staff, for laundry staff, for our maintenance staff, for our kitchen staff. These are standards we've shared with the homes for the aged, and we would be willing to continue to ensure that we do have ongoing training and services which would be coordinated.

The local level is where it's going to happen. I think that's the other thing that's very confusing at this point, what is the planning role? Are the district health councils going to be it? Who's going to plan all this stuff? It's got to be coordinated. Your placement coordinator has to coordinate your institutional with your community and how is that going to work because the institutional is all from head office and the community stuff is all from DHCs or other social service bodies.

So it would sure help if you'd just draw up the map and draw some pies and say, "Yes, these are the pies." Are they going to be the 14 regions or are they going to be the DHC regions or are they going to be the municipal regions? We'd sure like one set of boundaries and one planning body to go to at a local level. That would help.

Mrs Caplan: I don't know whether you've heard, but our party and our leader have often said that one size should not fit all and that local communities are best at solving problems. What was mentioned to me by a previous presenter was that perhaps on the local level, boards of health or health units with a lot of expertise in food management and quality outcome controls—they have all kinds of new terminology today—could be a source and a resource for assisting in this kind of a quality management program if it was a locally driven initiative. So it just occurred to me that maybe this legislation really is going in the wrong direction by trying to centrally control all those functions—

Ms Jourdain: That's the old model.

Mrs Caplan: —and should be more forward-looking to consider the idea of devolution of the—I'll use the term "quality management" or "continuous quality improvement values," because it is a culture change. We want to believe that everybody can do better

Ms Jourdain: You've got the two areas that are broken up here, because you've got the move to the 14 area offices, and your service agreements are going to be written with the local offices, yet your monitoring is coming from head office. So, yes, it's a good concept.

The Acting Chair: Thank you very much. Mr Wessenger has a short question that has not been asked before.

Mr Wessenger: I was very interested in this combined model of a retirement home and nursing home.

Ms Jourdain: Oh, great, we think they're fabulous.

Mr Wessenger: Are they separate? Is there any physical separation?

Ms Jourdain: Specialty Care happens to have two. In Keswick, we have a one-storey facility; one half is retirement home and one half is nursing home. In Kingston, our facility's a two-storey facility joined by an elevator.

Mr Wessenger: So the residents in the retirement home and the nursing home residents share any common social activities and so forth?

Ms Jourdain: Yes, to a certain level. The retirement home residents, when they come in, don't want to do that because they don't want to associate with the sick people and they don't want to know about that side of it. But as more and more retirement home people leave, say one spouse goes to the other side or a friend who is next door goes to the other side, then they'll go over and visit the other person and vice versa. So when you have bingo or church services or all the various activities, you'll find that they go back and forth. We do keep some activities separate just because there are generally two levels of clientele because of levels of care needs, but a lot of them are mixed.

Mr Wessenger: That leads into my second question. Do you see it basically as a retirement home, a low level of care or no care at all, and the nursing side having a high level of care, or are there several people living there where it could be interchangeable despite the level of care they require?

Ms Jourdain: I think there are always people in the retirement home who definitely would be eligible for the nursing home and are waiting for placement.

Mr Wessenger: Are there people in the nursing home who could change over?

Ms Jourdain: No, I don't think so. There might be a very small percentage. I think when you change the copayment, that'll totally change, because there are some people who cannot afford a retirement home who do go straight into the nursing home. The number is very small actually.

I think when the copayment issue is changed—and by the way, I'm very strongly in favour of that because I remember coming in when I actually used to work for the Ministry of Community and Social Services in my first life as a social worker and I used to fund services for the mentally retarded as a program supervisor. I went next door to the guy who was next to me, he used to fund homes for the aged, and I said, "Well, how do you get someone into a home for the aged?" I didn't even know about nursing homes then, of course. He said, "Well, you just get this little paper signed by the doctor." I said, "And who funds it?" He said, "The government funds it." I said, "What if the person pays?" He said, "Oh, well, whatever they get in the government cheque, they get to keep \$100 and that goes, and the rest is all paid by the government." I said, "What if the guy's really rich?" He said, "Well, it doesn't matter." I said, "This is fundamentally sort of wrong." This is 20 years ago.

But then I went on and did my own work with my own people and forgot about it until I got back into nursing homes. So I think it's great. Let people pay if they've got the money. I think the sliding scale you've got, while it has

some problems, is certainly easy to assess. I don't know what you do with the guy who has no income but has a zillion dollars in assets. I guess that's a perennial problem. But it's an improvement.

Mr Wessenger: Could I just follow up with one more thing about your combination home?

Ms Jourdain: Yes.

Mr Wessenger: Do you feel it's a good idea to have this combination?

Ms.Jourdain: Absolutely.

Mr Wessenger: I mean besides for financial reasons, because we heard from another presenter earlier today that, because he had a small nursing home, in order to make it financially viable, he had to make it combination.

Ms.Jourdain: Absolutely.

Mr Wessenger: So you think from a social and a financial basis, it's good?

Ms Jourdain: Oh, absolutely; from the resident's perspective and from the family's perspective. Actually, that's why our retirement home fills up faster than other retirement homes in the same community, because families really like to know they've got that. It helps the families and it also helps spouses and it helps friends. We just had an instance where we had to move a resident because there was water damage because of the storm. I shouldn't be telling you this, because we don't have any problems in our homes, but we had to move a resident in the retirement home. We just had to move him from one room to a larger room, a double room, for the same price. They're really shaken up, so can you imagine if you have to move not just down the hall to a nicer, bigger, better room but to a whole new building, to a nursing home. This way, at least when you're moving someone, you're moving them within the environment they know and with friends they know. I can't see the rationale for not supporting them, I really can't.

Mr Wessenger: Fine, thank you very much.

Ms Jourdain: Okay?

The Acting Chair: Thank you very much for coming before the committee.

Ms Jourdain: Thank you.

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RELIGIOUS HOSPITALLERS OF ST JOSEPH HEALTH SYSTEM

The Acting Chair: And now the Religious Hospitallers of St Joseph Health System. Sister Rosemarie, welcome to the committee. We appreciate your coming, and if you would identify yourself again for Hansard please and then begin your presentation.

Sister Rosemarie Kugel: My name is Sister Rosemarie Kugel. I'm president of the Religious Hospitallers of St Joseph Health System. The Religious Hospitallers of St Joseph Health System is comprised of health facilities located in Ontario, New Brunswick, Illinois, Wisconsin and the Dominican Republic. In Ontario, we operate Hotel Dieu Hospital, Kingston. It's a teaching facility affiliated with Queen's University. We also operate a community

hospital in St Catharines and health centres in both Cornwall and Windsor

In both Cornwall and Windsor, in order to improve patient and resident care, we have integrated governance, management and, to some extent, the programs of our acute care facilities with our homes for the aged. The linkages have existed for many years, but recently we have had them formalized. Through this integration, we hope to achieve both improved services and improved economic performance.

In considering amendment to Bill 101, we support the concept of placement coordination. However, our experience with placement coordination has varied. In both Cornwall and Windsor, we operate homes for the aged totalling approximately 400 beds. In each of these communities, there are strong linguistic, cultural and religious affiliations. We hope that the placement coordinators would be required to respect these realities as well as the person's right to choose. In addition, we hope that the placement coordinators would also take into consideration the service agreements as well as the funding levels determined for these facilities. We feel it would be appropriate to include these criteria in the legislation so that all coordinators are guided by the same criteria.

We also feel that the amendment is not clear regarding the rights of a provider. If a placement coordinator makes a placement which is inconsistent with the facility's mission, its service agreement or its funding level, a means of appeal should be available for both the user and the provider. This should be included in the act.

I stated earlier that we have worked hard to improve the quality of care which we provide by the integration of our homes for the aged with our acute care facilities. In some areas where we operate health care facilities, efforts are being made to develop a single entry system for access to residential care, extended care and acute care.

In Ontario, some of our acute care facilities are developing quick response teams to deal with appropriate access. Geriatric assessment programs deal with access to geriatric, acute and chronic care as well as placement coordination to address access to residential care. In Ontario, we also operate an apartment facility for the elderly which is accessible to self-pay tenants, partially subsidized tenants and, in some instances, handicapped tenants. We have developed these corporate linkages to assist in providing ready access from residential care through to acute care. We know that this benefits the users.

It appears that Bill 101 addresses the coordination of access in only one part of the health care delivery spectrum. The need to coordinate health care across the spectrum in an integrated fashion still remains outstanding. So we believe this requires some consideration.

Regarding standards, quality and inspection, our health care centres in Ontario are fully accredited facilities and have received the highest accreditation award. We believe that these results flow from the commitment that the boards, management, staff and physicians have to the mission statement of the facility, which stresses, among other things, the Christian values of: (1) respecting the dignity of the person; (2) providing quality holistic care;

and (3) being responsible stewards of the human and financial resources of the facility.

Over the years, our challenge has been to call many people to join us in striving to carry out our mission of serving the poor, the sick and the needy. At times, we are overwhelmed with the public's response and support to the care given in our health care facilities. They have been very positive.

We are concerned about the tone of Bill 101. Rather than calling upon us to develop an acceptable mission statement and to perform in accordance with our mission, Bill 101 proposes the punitive loss of inspection and retribution which is an authoritarian rather than the collaborative approach held up as a model by this government.

Voluntary accreditation has been a successful tool in assessing the quality of care in acute and chronic care facilities. We suggest that it be implemented in residential care as well. The Public Hospitals Act gives the Ministry of Health the authority, where there is an abuse, to appoint investigators, inspectors and supervisors who may take steps deemed necessary to improve the quality of the management and administration of the hospital as well as the care and treatment of patients. We suggest a similar approach in Bill 101.

Earlier in this submission, I referred to the linguistic, cultural and religious realities that exist in our facilities. We try to respond to these concerns in our mission statement and the manner in which we operate our facilities. In recent years, a number of ethical issues have arisen. In each of our facilities, we have established ethics and values committees to help us respond to these fundamental concerns.

Bill 101 does not deal directly with governance issues. We understand that we may be hearing more in this area a little later. When governance is addressed, we hope that it will be enabling rather than directory, which will permit us to continue to respond to the needs of those we serve by dealing openly with the serious ethical issues which are now surfacing.

Relative to funding, we have been involved in providing residential care in Cornwall and Windsor for nearly 50 years. We have participated in the accreditation process for these facilities and have addressed ways and means of improving the quality of care we provide to our residents as well as improvements in management and administration. Our greatest concern has been inadequate funding. Perhaps the proposed service agreements and the new funding levels will assist in stabilizing the funding issues. We hope so, because the present financial situation cannot continue or we will soon find many of our long-term care facilities unable to continue to serve those in need.

We thank you for the opportunity to present our submissions. We recognize and endorse the reform of long-term care. We desire and wish to collaborate with government in ensuring that those in need have access to our facilities and that the care they receive is appropriate and cost-effective. Lastly, we hope that the Ministry of Community and Social Services will recognize that access and quality care can only be provided when the facilities are adequately funded. Thank you.

The Acting Chair: I thank you very much for coming before the committee. You bring back memories, because I remember when I was a student going to high school here in Kingston I did do some work at the Hotel Dieu Hospital; you provided a summer job for a student who needed it. Now, Mr Hope, do you have something or Mr Owens?

Mr Owens: Mr Hope is the parliamentary assistant, so I'll defer to Mr Hope.

1700

Mr Hope: I got in here a little late so I was reading up and getting caught up on it. One of the areas I want to touch on because it seems to be a high emphasis on the inspection process—I heard those individuals who are being accredited through the accreditation and I believe it's about 50% of the nursing homes and the homes for the aged that are accredited and 50% that are not.

But I've heard through the presentations people are saying consistency of all three different—you know, and then when it comes to inspection there seems to be a little bit of non-consistency. My biggest fear is around—I'm hearing in your presentation you're talking around the Public Hospitals Act, where the minister would have the authority to appoint an investigator and an inspector. So I'm taking that to be that it has to be the will of the individual to file a complaint.

Sister Kugel: Not necessarily. That can be from family. A request can come through that there is abuse. Staff can present it. That is not necessarily the way.

Mr Hope: But we're looking forward for the general public to come forward other than working on a proactive approach and trying to go in and do, because those were accredited, and those who have good standards and everything else—I'm sure the inspectors would be better off to deal with those who are not complying. I've had one problem in my own area where the owner just walked away from it and I talked to the workers of staying on and making sure that we could get a placement coordination in place.

I'm really concerned. I was going through some of the history books looking at health and safety issues. I believe it was the Tory government that brought in the legislation, and everybody was concerned about the inspector title that was there. They were saying, "Well, why should we need inspectors when people can speak?" Then once the system was in, those who have a good working relationship with inspectors continue to have that. I don't think they come down with a hammer or the militancy.

I understand what you're saying. You've got a good record. I know about your facility in Windsor. I'm just saying in order for consistency, we just can't say, "Those good ones that have accreditation don't need inspectors and those bad ones that are not accredited need inspectors." I'm wondering about consistency across the board. I've been hearing that quite a bit.

Sister Kugel: I believe that, as I had mentioned, I think accreditation—and it's strongly recommended that it would be across the board. I believe the speaker before me kind of insinuated or made the comment that it's a little against professionalism. If you're always waiting for the

possibility of an inspector to come in, that's not the manner in which you'd like to function.

If you would be carrying through on an accreditation process on a regular basis and you're following standards, it's very easy to gauge your whole operation, and that goes through all levels. Also, you have your quality assurance committees in all your facilities now. Certainly that's reported to your board. Your board requires that it receives the reports. I think it takes a little bit away from your independence or the whole sense of accountability of your board for your facility and for the operation of it. So I still believe that accreditation would be better.

Mrs Caplan: I'm very familiar with your facilities. Nice to see you, Sister. I think we should clarify something. I've been advocating over the last couple of days exactly the model that you've proposed and I want to put on the record that we've never discussed this, your presentation, before, and the fact that your ideas are very similar to what I've been suggesting is coincidence. Is that correct?

Sister Kugel: That's right, because I've never heard you. I wasn't here.

Mrs Caplan: I just thought we should put that on the record. There was no collusion in the development of your presentation for the committee.

Sister Kugel: None whatsoever.

Mrs Caplan: I agree very much with your proposal and I believe that it is forward-looking and outcome-oriented and positive and will result in improvement rather than the big-stick approach. I also have had, as you know, opportunities to see how the Public Hospitals Act process works and it does work, because it is a very big stick that you don't want to use unless out of a concern for the jeopardy of individuals.

For Mr Hope and anyone else who's interested, anybody can trigger that concern, and the minister can send in an investigator under the act, but usually you don't even have to send an investigator under the act. You can contact and say, "Do we have to use the act or can we send someone in to investigate without the act?" So the process of that act has worked extremely well.

Mr Hope referred to the occupational health and safety, and I would point out to him that the whole concept of the adversarial labour management inspector attitude is just outdated, outmoded and what we're looking at is new. You may want to comment on that further, but you've really called for a statement of principles.

We've also been talking here about an amendment that would include in the legislation a statement of the guiding principles, which would be multicultural, linguistic, religious, social and so forth. Would you like to see that in the legislation?

Sister Kugel: I believe it would be a good idea, but I think when we were making our statement that this would be taken into consideration by that placement coordinator very much, and I think that's why we were stating it, whether it really needs to be in there. It would be a good idea.

Mrs Caplan: The suggestion for an amendment would be more of a statement of principles that would guide the placement coordination—

Sister Kugel: That's right.

Mrs Caplan: —and also the long-term care facilities as they work together to provide better care. That was the concept of a statement of principles, to guide the legislation. Is there anything further you want to say—

The Acting Chair: This is the last question.

Mrs Caplan: —on the proposed model and why a positive approach is better for the people you're trying to care for, and perhaps the role of the staff, how it's changed?

Sister Kugel: I'm sorry, I'm not quite-

Mrs Caplan: In providing improved care, how you get your staff involved in your process.

Sister Kugel: The staff would be very much involved with your quality assurance programs, and that is ongoing. They get the reports back, and any deficiencies would be brought back to each of your departments.

Mrs Caplan: There's a lot of monitoring.

Sister Kugel: It's monitored, yes, and then the board receives a report and if there hasn't been improvement, it's taken back. So at all levels it's monitored. The monitoring is carried out within your facility, not heavy-handed. When it has to be, then we would agree with that, but to put it in a regulation for everyone who is really doing very fine work—and I think most of our homes are and your long-term facilities are. Collaboration's the name of the game, and not the heavy hand today, I would say.

Mrs Caplan: Thank you, Sister.

Mr Villeneuve: Thank you, Sister. I must tell you, I'm quite familiar with St Joseph's Villa in Cornwall. Sister Kane, on many occasions when she was there, told me about the funding problems. I guess it hasn't changed a great deal.

Sister Kugel: It hasn't.

Mr Villeneuve: Is it still the situation where your patients are much older and much more care-demanding than all other facilities? I can only speak of Cornwall, because that's the one Γ m familiar with.

Sister Kugel: I believe when they come in, they're residents. At this point there would be 50 residential, 100 extended care. When they first come in, they're residents, but their level of care changes and your funding does not accommodate that. That base does not change. So this is where the problem is from day one. It's just continued, because there has not been the reform.

Mr Villeneuve: The other one then—we're not going to solve it with this particular committee—but the moral and ethical issues that you touch upon I think must be borne in mind by this committee, by the minister and by those who will be administering Bill 101, because we know what's before the courts now and it's going to get much more complicated. It's great that you brought it to our attention. Thank you very much.

Sister Kugel: There will be—and this is where we are initiating—our ethics and values audit committee, and that will be audited too. But certainly we have policies that we will have to develop. As you know, the whole idea of euthanasia is being brought forth, nutrition, hydration. I

think all of these issues need to be considered, so they will be dealt with within our committees.

The Acting Chair: Thank you very much, Sister, for coming before us and giving us your views and, I would say, good advice.

Sister Kugel: Thank you.

1710

ASSOCIATION OF ROMAN CATHOLIC CHAPLAINS

The Acting Chair: Now the Association of Roman Catholic Chaplains, Father Stitt, Welcome to the committee.

Father Ken Stitt: Thank you very much.

The Acting Chair: If you would identify yourself for Hansard, please, and then present your report.

Father Stitt: My name is Ken Stitt. I'm the director of the Association of Roman Catholic Chaplains for this area, referred to as ARCC. I understand, I just discovered, you don't have a copy of my brief. I assure you it's just that—it's very brief—and ask you to bear with me for a few moments.

The Association of Roman Catholic Chaplains came into being in this archdiocese of Kingston in 1977 to provide pastoral workers, mostly lay workers and chaplains, with an educational program designed to promote specialized pastoral care to our seniors residing in nursing homes in this area, long-term care facilities and hospitals, both the chronic and acute care hospitals. Being parish-based—and we think that's the secret of our organization—the association strives to reconnect, where possible, our senior population with their respective faith family. In this manner in this training program, we believe we are indeed empowering the laity to be actively responsible for health care at the local level, meaning the parish or the congregation.

Our association sets standards of education whereby all graduates are certified to provide top-quality, we believe, pastoral care. Having a Roman Catholic basis, our membership includes pastoral workers from the Anglican Diocese of Ontario and also the United Church of Canada in this Bay of Quinte Conference.

The archdiocese of Kingston, our area, stretches along Lake Ontario and the Bay of Quinte from Trenton on the west to Chesterville on the east and goes north to include Carleton Place and Marmora. In a recent study to find out how many beds we had in the area, we discovered we have a total of over 3,700 long-term care beds occupied by seniors within the archdiocese. Understandably, we administer to more than this number, because our approach is not just archdiocesan but rather ecumenical and holistic.

We are well aware of and recognize the unique aspects of culture—someone mentioned culture before—family support and spiritual values—Sister mentioned spiritual values—of seniors with whom we work. In the past, we understand from experience that admission to long-term care facilities did respect the aforementioned cultural milieu of the person's ethnic traditions, family involvement, family locale. In the process of placement in the past, we understand, some degree of choice was indeed exercised by the patient, the resident or the family.

While the proposed amendments to Bill 101 goes a long way in supporting the uniqueness of the senior population, we do have some reservations about the role of the placement coordinator. That came up before. In our society, the right of choice has been fundamental to the human dignity of the individual. We of ARCC fear that this basic human right of choice might be eroded if the individual is not given choice in placement.

In reading the proposed legislation, the placement coordinator could possibly and most likely will control—a funny word, "control"—placement to one or more facilities. This placement coordinator may receive a request from an individual or family to be placed in a specific home or placement because of its locale, its religious or cultural affiliation or its ethnic complexion.

We are concerned as to how much weight the applicant's choice will have under the proposed new system of the role of the placement coordinator, so we ask respectfully that the committee and the government proceed with great care in this sensitive area of placement.

I thank the committee for the opportunity to be part of these proceedings. Thank you. It was short.

The Acting Chair: Thank you, Father. We begin the questioning with Ms O'Neill.

Mrs O'Neill: Father, thank you for coming. I've just had a very personal experience of my dad's death last month. In the hospital—actually, they call it a health facility—in a large Ontario city, there is a pastoral team of 32. It was an outstanding experience. I would suggest that the pastoral care was every bit as much of importance to myself and likely to my father as the medical care that we received in his last few days.

I really liked your little—I think it was almost an aside when you said, "Funny word, 'control.'" I think any of us who have brought up a family or have experienced any kinds of personal relationships know that is a very strange word when we talk about individuals. I think you're highlighting from a very poignant perspective the right of choice and the jeopardy that many feel the right of choice is in with Bill 101.

We have suggested, and maybe you heard us earlier this afternoon, setting some guidelines or statements of principles in the bill regarding the role of the placement coordinator because we think it's so fundamental.

I think communities, and yours is one, where placement coordination has gone on quite successfully—levels of trust have been built over perhaps 20 years in some communities—people are still feeling fairly comfortable. But with one individual, and it could be one individual according to the legislation, or an agency where there has never been this experience, or certainly in the territories that are not as organized as many of our urban areas, I think there's a great deal of fear.

You bring it, as I say, from an area of work that you've taken upon yourself where you feel that you need the flexibility, you need the guarantees that the people you have worked with over the years have been able to receive in this community and you want those maintained, if I can paraphrase what you've been saying.

I thank you for coming. I think you are the only pastoral care worker who has come, or chaplain, as the term used to be used more frequently. We've had a lot of people talk about your work and present it as part of their brief, and we've had people talk about pastoral care committees, but I think you're the first one who's come in person to present from your perspective your daily work over the last 20 years, so thank you so much.

Father Stitt: Thank you.

Mr Villeneuve: Father, thank you very much for coming. I have the privilege of representing the far-easternmost section of the Kingston diocese and it's nice that you're on record here with placements being of major concern; 3,700 beds, I believe I heard you mention. Surely, with that kind of accommodation, local autonomy is most important. We've had it brought to the attention of the committee time and again, and I think you simply reinforced the fact, that local people with input from the people of the area can do it so much better than a hierarchy or a bureaucracy or controllers, as I guess you've used. So I don't have a question for you, Father, other than to say thank you for emphasizing that to the committee, to the minister.

Father Stitt: Thank you, Mr Villeneuve.

Mr White: Thank you, Reverend Father. I agree wholeheartedly with Mr Villeneuve's comments about the importance of the placement coordination and the services being operated locally. The funding of course for those local services has to come from the province. That, I believe, is the very stated intent and has been made several times by the parliamentary assistant, that the existing placement coordination services, the existing services, are the ones that will be doing these services, but they will be coordinated and informed by a local committee from some of the facilities you mentioned, from some of the local services.

What I would want to ask of you would be whether you feel that the importance of the spiritual and social needs of the elderly should be there as directing those committees, as directing that placement coordination in the regulations.

Father Stitt: Do I feel they should be?

Mr White: Yes.

1720

Father Stitt: Yes. Unofficially, we are meeting with people from both dioceses and with the local United Church and the district health council, just informally, on this very issue, how we can share and be part of what's going on.

So often I find in long-term care facilities that the resident has been removed from their faith group and they're just at sea, and I've seen wonderful things happen when they have been reconnected with the faith group, great things.

Mr White: I'm wondering also if I could ask you about how your services work. You've mentioned the involvement of the United Church and the Anglican Church. My own experience was that my family were Presbyterians. Not unlike Ms O'Neill, the pastoral care that was offered to my family on the demise of my father

was every bit as important as the medical care. How do you interrelate with other faiths?

Father Stitt: I'm delighted you asked me that.

Mr White: I thought you might be.

Father Stitt: I think about seven years ago I was approached. The university was looking for some funding for pastoral training and we were looking for a program, and so there was a happy marriage. What happened is we have developed a program. There are two programs going on. There's one for professionally highly paid pastoral workers. Our program here in this diocese consists of 200 hours and we train people to work in a volunteer capacity. Of all the churches, we seem to be about the only trained program around for pastoral workers.

The only people who have joined us so far is the Anglican diocese and individual members from the Bay of Quinte Conference of the United Church. We're going to run three programs for three years and so we hope to attract—we have new programs starting on April 16 and it will be a multifaith group, we hope.

Mr White: So you even involve the canny Scots, you hope.

Father Stitt: Yes.

Mr White: Thank you.

Father Stitt: Thank you for asking.

The Acting Chair: Thank you, Father, for coming and providing us with this information. As Ms O'Neill said, you are the first, so you are unique, and I thank you for being here this afternoon.

Father Stitt: Thank you very much.

PROVIDENCE HEALTH SYSTEM

The Acting Chair: The last presentation this afternoon, Providence Health System. Sister Sheila Brady, welcome to the committee. Perhaps you would identify yourself for Hansard, please, and give us your presentation.

Sister Sheila Brady: Thank you very much, Madam Chair. We were falsely called Providence Help System, and maybe it wasn't so false. They do call on us for help quite often.

My name is Sister Sheila Brady, a Sister of Providence of St Vincent de Paul. I am representing our Providence Health System in Ontario. Our congregation sponsors eight homes and hospitals across Canada from Ontario to British Columbia, with extensive experience and commitment to long-term care.

Here in Kingston we founded and continue to sponsor Providence Continuing Care Centre, which is comprised of St Mary's of the Lake Hospital and Providence Manor, a charitable home for the aged. In 1861, our founding sisters gave refuge and compassionate care to the elderly, poor and sick in Kingston and area. Our financial resources were nil and our sisters were obliged to go begging at that time, and now we come begging to the government.

A long and excellent tradition in caring for the elderly has continued, and from this base we believe we have much to offer your committee as you seek to amend legislation regarding long-term care in homes for the aged and nursing homes in Ontario.

Providence Health System supports this government's initiative in redirecting our long-term care system. Reform is needed and we laud your courage to do so. It has been a frustrating time for us as well, struggling with the inequities in resource allocation to Providence Manor and erosion of our equity through deficit funding, while maintaining high standards of care. We continue to address the needs of our residents holistically in collaboration with them. However, we feel there are serious potential implications to Bill 101 with its amendments of various statutes dealing with long-term care.

We view Bill 101 as regressive in some areas, providing a tighter reign on homes whose standards are unacceptable, yet at the same time punishing those homes that strive for excellence in resident care. We question whether this proposed legislation balances the protection of the frail elderly while ensuring cost-effectiveness in the system.

We encourage the government to build on the strengths already in place and not attempt to homogenize homes with central control in inspectors' hands.

Providence Health System would like to address the following implications noted in the proposed legislation: First, governance issues; second, quality care issues; and third, residents' right of choice.

Governance issues: The strength of our home for the aged, Providence Manor here in Kingston, lies in its governance by a volunteer board and a high calibre of administrative staff. These board members and leaders are committed to ensuring safe, compassionate care in the spirit of our founders within the limits of scarce resources. They have been and are now accountable to our residents and their families, to the Kingston community, to the Sisters of Providence of St Vincent de Paul and to the Ministry of Community and Social Services.

We recommend that you build on governance autonomy, authority, accountability and flexibility to meet the ever-changing needs of our elderly and disabled residents and day clients.

The Sisters of Providence and our governing board of Providence Continuing Care Centre have been leaders in continuing care in Kingston. As stewards of a denominational home, we are vigilant in ensuring that legislation respects our tradition and mission in long-term care, just as we respect you and your role to address the inequities in the health system with dwindling resources.

Quality care issues: Bill 101 promotes quality assurance, and with good reason. The leadership team at Providence Manor is instituting a total quality management program which embraces far more than just quality assurance to meet high standards and expectations in resident care. The principles of this program empower our employees to make decisions at the lowest possible level and motivate them to strive for excellence in quality care.

We urge you to balance costly outside inspections with strong total quality management principles which our voluntary board accepts as a major responsibility to ensure high standards of care. Freedom of choice: We have collaborated and cooperated with the staff and placement coordination service in Kingston for many years, both at Providence Manor and St Mary's of the Lake Hospital. Again, we urge you to build on that strength. Bill 101 addresses eligibility of residents based on levels-of-care funding guidelines. We trust the coordinators will also take into consideration placement based on spousal or family approximation, on their preferred culture and on the religious affiliation of the home.

We agree in the fundamental concept of appropriate access and utilization of scarce resources, but the rights of individual residents and their families must be respected as well

In the legislation, an appeal process is to be initiated to determine ineligibility of resident placement. However, individual homes are denied an appeal process, and we urge you to review this.

In conclusion, I wish to thank you for the opportunity to express our concerns here in Kingston. We would request that this committee be attentive to our concerns and address them

The Acting Chair: Thank you very much for coming forward. If we could, we'll begin the questioning with Mr Villeneuve.

1730

Mr Villeneuve: Sister Brady, thank you. Again, the placement seems to be a major concern. I think you've articulated well the fact that indeed homes should also have in place a mechanism whereby they could appeal and I'm just wondering—I'm subbing on this committee. I've not been a member of it at all and I'm privileged to be able to. I'm learning here as well. Would the parliamentary assistant want to comment on that, if indeed that's being considered? When we look at religious orders operating, certainly there is a situation here that—

Mr Wessenger: I can only explain what's in the legislation right now in the sense that the consumer choice aspect is very much a part of the process in which the placement coordination works. It's a basic principle. Certainly we're looking at ways to see if we can make that clearer by having some statement of principles or something of that nature in the legislation. So yes, we're looking at that.

At the moment there is a right of refusal of a facility, but other than through the courts, there would be no other appeal process. The only thing I can say is that would be a matter that would be taken under consideration.

Mr Villeneuve: Sister, it sounds positive. It sounds like they're listening.

Sister Brady: It sounds like they are.

Mr Villeneuve: Thank you. **Mr Hope:** We always listen.

Ms Carter: Thank you for that very brief and concise report.

First of all, the governance issues: This Bill 101, as you know, is only a partial bill as far as reforming long-term care is concerned. I understand that governance is one of the things that is going to be looked at later. Obviously, it is a matter of great concern but it's not, as such, dealt with

in that bill, so we're still looking for whatever information will be on that.

I'd also like to raise the quality-of-care issue. That's one that keeps on coming up. Obviously, we all want the best possible quality of care in all our institutions. I think the point is that a lot of institutions do not need a lot of external monitoring. They have internal mechanisms, but sometimes more than that is needed. When we look at the spectrum of possibilities, the Advocacy Act is going to be coming into force. That will give residents a right of individual appeal other than what they have at the moment. They are going to have personal plans of care which are going to be available to them, so hopefully that will help.

We know there are residents' councils in quite a lot of facilities, and we feel that's a very helpful thing too, although not something you can legislate and enforce,

because it has to be spontaneous.

But having said all that, there is still the problem of homes which are not meeting standards. We do know from some of our presenters that those homes still very much exist. I was just wondering if you could comment on what we do about that and whether in fact some form of inspection is not needed.

Sister Brady: I think I mentioned that especially with inspectors coming in, we're just afraid all the homes will be tarred with the same brush and we don't think some of them really need to be.

Ms Carter: I agree with that, but what about the others, and how do we legislate for that?

Sister Brady: When I was in Alberta, and I worked there as well, they had what they called a premier's committee, I believe, that used to come around to the hospitals, the homes all over the province. They didn't come as inspectors; they came as a committee of concerned citizens. That was a very interesting committee. We never looked on them as real inspectors and we knew that our quality was high. We had very few concerns in our facilities. They certainly righted some of the wrongs that were going on in some of the health facilities I know. So that is one area this committee might look at. It's not as threatening as your inspectors. I hate to see us go back to that and put the control in their hands. That committee made recommendations and we made sure we did something about them, but it didn't carry a heavy stick.

Mrs Caplan: Thank you very much, Sister, for an excellent presentation. It's been a long day. I think I speak for all members of the committee in that we've had so many excellent presentations here. We've been hearing the same themes but in very different ways and from personal experiences. The themes you've raised are similar. I'd like to be specific and ask you whether or not you would support the following kinds of amendments. Would you support an amendment that made accreditation mandatory rather than voluntary?

Sister Brady: Yes, I would, very much so.

Mrs Caplan: Would you require, either in the contract or just as a requirement of the ministry, that quality management be the approach for continuous improvement within the facility?

Sister Brady: Yes.

Mrs Caplan: I disagree with Ms Carter. The Nursing Homes Act makes residents' councils mandatory. Would you be comfortable with this legislation mandating residents' councils for all long-term care facilities?

Sister Brady: I think you'll run into a problem. We're finding that more and more in our homes are getting very frail, and not that many can serve on residents' councils.

Mrs Caplan: What about the concept of resident or family councils so you could have the family involved?

Sister Brady: Family; that would be fine. Yes. We use ours very much. We really listen to them and they have a lot to say about their care.

Mrs Caplan: Again, comfortable with financial disclosures?

Sister Brady: Yes.

Mrs Caplan: Would you be comfortable with an amendment that allowed or gave the right to long-term care facilities to refuse an admission on the basis that they didn't think they could provide appropriate care, but allowed for an appeal of that right and an exception in emergency situations?

Sister Brady: That sounds reasonable, yes.

Mrs Caplan: Also, I'm assuming that you'd like that statement of principles we talked about.

Sister Brady: Yes, very much so.

Mrs Caplan: The other is an amendment on the amount of time that we've been talking about. This is the question I have for you. How long do you think it's reasonable to give for an appeal process?

Sister Brady: I haven't had any experience in that, so I really can't answer that.

Mrs Caplan: Okay, thanks very much. The only other thing we'd asked for was a definition of "long-term care facility." It's absent from this legislation. I wonder whether you think it's important or whether a long-term care facility knows it's a long-term care facility and you don't need to try to define it.

Sister Brady: I think they know. Mrs Caplan: They know? Sister Brady: Yes, I hope so.

Mrs Caplan: Thanks.

The Acting Chair: Thank you very much, Sister, for coming today. I wish, at this time, to thank all of the presenters who have taken the time to come before us. It really does help us, especially those who have had to travel. I know some of those people have left and I should have thanked them as they left, but we really do appreciate your efforts in getting here and we certainly do appreciate the kind hospitality shown to us here in Kingston.

Mr Hope: I think I recognize the dedicated three who have been sitting there since early this morning.

The Acting Chair: I guess so. You win the medal of longevity, or something like that. Also, thank you to the committee members, who have been fairly congenial today. I really want to congratulate you all.

Mr Hope: It's Elinor. She keeps trying to provoke me.

The Acting Chair: Let's not start. Certainly, thanks to our clerk, who looked after us so well this week, our legislative research person, all our ministry staff who have accompanied us and also our Hansard people. Thank you very much for an enjoyable week.

Mrs O'Neill: Madam Chairman, before we adjourn, could you give us, now that this series of hearings has come to an end, when we meet next as a committee? I think that decision's been made, hasn't it?

The Acting Chair: I believe it is March 8 at 10 am, Queen's Park, probably in committee room 1 or 2.

Mrs O'Neill: It's for hearings, is it?

The Acting Chair: Yes, the Toronto hearings.

Mr Hope: One of the things we've discussed as a subcommittee is that the total week of March 8 will be

public hearings, and then the Tuesday, which will be March 23, we'll move into clause-by-clause.

Mr Wessenger: No. May I just clarify that?

Mr Hope: No, you're not going to. **Mr Wessenger:** On the 22nd and 23rd—

Mr Hope: The 22nd is a Monday. We're going to exclude the Monday because some people will just be returning from March break. So we've now moved to the Tuesday and the Wednesday, March 23 and March 24, two days for the clause-by-clause. That's the intent. It sounds very good. There'll be clarification of that on March 8, but the week of March 8 will be totally public hearings.

The Acting Chair: Thank you very much, Mr Hope, for that information. The committee stands adjourned until March 8 at 10 o'clock.

The committee adjourned at 1741.



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair / Président: Beer, Charles (York North/-Nord L)

*Acting Chair / Présidente suppléante: Fawcett, Joan M. (Northumberland L)

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*Owens, Stephen (Scarborough Centre ND)

*White, Drummond (Durham Centre ND)

Wilson, Gary (Kingston and The Islands/Kingston et Les Îles ND)

Wilson, Jim (Simcoe West/-Quest PC)

Witmer, Elizabeth (Waterloo North/-Nord PC)

*In attendance / présents

Substitutions present / Membres remplacants présents:

Caplan, Elinor (Oriole L) for Mr Daigeler

Carter, Jenny (Peterborough ND) for Mrs Mathyssen

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mr Jim Wilson

Johnson, Paul R. (Prince Edward-Lennox-South Hastings/Prince Edward-Lennox-Hastings-Sud ND) for Mr Drainville

Villeneuve, Noble (S-D-G & East Grenville/S-D-G & Grenville-Est PC) for Mrs Witmer

Wessenger, Paul (Simcoe Centre ND) for Mr Gary Wilson

Also taking part / Autres participants et participantes:

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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Monday 8 March 1993

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Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée

Chair: Charles Beer Clerk: Douglas Arnott Président : Charles Beer Greffier : Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 8 March 1993

The committee met at 1005 in committee room 1.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. We begin our final week of hearings. This is the standing committee on social development and we're here to discuss Bill 101, An Act to amend certain Acts concerning Long Term Care.

CANADIAN UNION OF PUBLIC EMPLOYEES, ONTARIO DIVISION

The Chair: The first representation will be made this morning by the Ontario division, Canadian Union of Public Employees. We'd like to welcome their representatives to the committee. Please take a seat. If we need another chair, feel free to move the camera out of the way. Once you're settled, would you be good enough to introduce yourselves for Hansard, then please go ahead. A copy of your submission has been circulated.

Mr Sid Ryan: Good morning. My name is Sid Ryan. I'm the president of the Ontario division of the Canadian Union of Public Employees. With me is Ruth Scher; Ruth is a senior research officer in CUPE. Flo Taffe is also with us; Flo is the chair of CUPE Ontario's health care committee, and also a nursing home worker. Also with us is Jim Woodward, CUPE Ontario's legislative assistant.

On behalf of the 170,000 public sector workers CUPE represents in Ontario, 40,000 of whom work in the health care field, we do appreciate this opportunity to outline our views on Bill 101 and the future of long-term care in our province.

Let us be frank: Our main difficulty with Bill 101 is that we've been asked to comment on legislation restructuring the delivery of long-term care in this province without having seen the government's detailed framework for restructuring. Although we are operating in the dark, we believe the standing committee must see the complete picture, that is, the ramifications of long-term care beyond the limits and parameters of Bill 101. Consequently, our presentation and brief will explain CUPE's concerns about the overall direction of long-term care reform, as well as deal with specific aspects of Bill 101.

As we reviewed Bill 101 and the overall plan to restructure long-term care, we were struck by the significant shift in policy approach they signal. In fact, this actually marks the end of a 20-year period in long-term care delivery and ushers in a new and very disturbing era.

We are seeing the culmination of a clash between two opposing views of society. On the one side of the battle line is the view that people have basic rights to a share of the country's resources. This view supports collective financing of human services through progressive taxation. It holds that people are entitled to health care services that are universally accessible, publicly funded and run on a non-profit basis. On the other side is the view that resources are available to be controlled and owned by a few people at the expense of the majority. This side advocates commercialization. It says universal programs which benefit everyone should be replaced by selective ones. It wants the burden of paying for services to be shifted from the tax-supported public system back to individuals.

The battle between these competing divisions has been waged on many fronts. Health care is just one of them, but it is crucial, because it has a huge impact on the quality of people's lives. We believe that commercialization must be fought, and more than that, it must be turned back. If it is allowed to expand, it will inevitably lead to lower-quality services, unequal access, lack of accountability and the danger that public policy would be even more strongly determined by corporate interests. We believe we cannot afford to let that happen.

In the area of long-term care reform, much of the long-term and acute care reform is supposed to be based on a comprehensive and expanded system of community agencies providing home care services. The government says this approach will meet the needs of the elderly by allowing them to live at home, in their communities, instead of going into a hospital or another long-term care facility. The idea sounds sensible: It appears to give people more options, more choices. But let's take a look at what's really happening.

First of all, despite the promise to maintain chronic care hospitals at their existing levels of service until the chronic care roll study is completed. A number of these hospitals have been forced to close beds and restrict services to seniors and people with disabilities. But where are the community-based services that are supposed to provide the cushion for what's taken place in the chronic care system? Secondly, the huge cutbacks that are taking place in our acute care hospitals will result in thousands of jobs being lost and beds closed. Front-line services are simply disappearing into thin air almost overnight.

Seniors occupy 50% of acute care beds. The Senior Citizens' Consumer Alliance for Long-Term Care Reform has pointed out to the government that the closures and cutbacks in acute care will force tens of thousands of seniors to seek more appropriate care from the community-based home care agencies. Again we ask, where are these

agencies? Where are the expanded services that take the place of the substantial ones that have already gone missing? What's the plan?

We don't believe there is a plan, at least not one that aims at delivering equivalent services. The plan constructed by the government is really all about cutting back service and care and placing the burden of responsibility back on the shoulders of individuals and families. For a variety of reasons, the elderly, people with disabilities and their families may not request home care services but may prefer some other setting, such as along-term care facility. With a freeze on nursing homes and homes-for-the-aged beds and the reduction in chronic care hospital beds, there will simply be no real care alternatives for families. Waiting lists will be so long that matching the appropriate facilities to the care needs of the individuals, including ethnic, linguistic and geographic preferences, will be virtually impossible.

We'd like to focus on where we believe the burden will be placed as a result of this change in direction of long-term care: We believe women will be hit the hardest. Under this new plan, there will be a lot more pressure applied by the proposed placement coordinators to push people into providing home care. Think about it this way: If you cut beds, services and people from the acute and chronic care part of the system, and if you take into account that waiting lists will grow even longer for long-term care facilities, the only place left to put people is either back in the home or out on the street, kind of like what happened not too long ago when the mental health care was supposedly shifted from hospitals to community-based services. While hospital beds were closed, the necessary services never materialized, and ex-psychiatric patients were left to fend for themselves.

Now, as last Saturday's Globe and Mail reports, thousands of vulnerable adults live in squalor, in unregulated rest homes and boarding houses. Most of these bootleg nursing homes are horribly understaffed and living conditions are deplorable. Owners hire mostly unskilled and untrained workers because they are too cheap to hire higher-paid health care aides and RNAs. You can't close down all the options and then call it choice; it's anything but. It's actually a forced march back into the earlier century. And it's women who will bear the brunt of this new order, because despite important political advances that women have made over the past decade, to a large extent they are still the primary care givers in the home; that means there's going to be more pressure on women, not less, to take on either a triple burden of responsibility or withdraw from the workforce entirely.

This plan is an attack on all the hard-fought gains that women have made through their unions and political organizations. That fight for equality has been waged on many fronts. To get into the paid workforce in the first place and get out of the low-paid job ghettos, it has been a struggle for pay equity, for employment equity and much more. Now we are seeing an orchestrated plan that once again relies on women to fill in the cracks, and they are expected to do this in the absence of any meaningful child care programs, which are absolutely crucial. In fact, 15,000 families are on the waiting lists for subsidized child care. Over the last year, more than 1,000 child care spaces

have actually been lost from the system. How on earth do we expect anyone to cope in this kind of climate?

Women workers who are actually in the workforce will also be hit hard. The long-term plan will also adversely affect women in the area of paid work. The health care system has long been recognized as a ghetto of lower-paid, predominantly female employment. Since 1974, there has been steady progress made in advancing the employment status of all unionized institutional care workers.

Just when collective bargaining and pay equity had begun to address these inequities, the government's strategic plan is to transfer work to the community sector—traditionally lower-paid work.

Thousands of decently paid, secure, unionized positions in institutions will be eliminated and replaced by low-paying, less secure, unorganized jobs in the community. This, of course, will all end up being a boost for the commercial operators.

There are some other problems with the government's approach to home care. We fear we may see an accelerated expansion of the private sector into this area. Since the 1970s, Ontario's drift to for-profit service provision has proceeded by both design and default. But with this plan to restructure, we now proceed by design to throw open the doors to the private sector, and that's bad news for workers, for consumers and for the idea of a publicly funded, not-for-profit system.

As an example, in 1978-79, the number of home care hours provided to Ontario residents was 82% non-profit and 18% commercial. By 1988, the ratios had shifted to 62% non-profit and 38% commercial. At a CUPE conference last fall, the former Health minister, Frances Lankin, stated that the ratio was now closer to 50-50.

Obviously, the increase in the commercial sector has been at the expense of the not-for-profit sector. This will result in a greater inability to develop, monitor and enforce standards of care. And it means money, our money, is simply skimmed off the top in the form of profit. If you think health care dollars are scarce now, just wait and see what happens when the for-profit sector expands.

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Between 1976 and 1989, seven out of 10 provinces reduced the number of private nursing home beds. But in Ontario, the percentage of private beds actually increased from 47% to 54%, making this province the biggest supporter of the private sector in the delivery of extended health care services.

In addition, the Ministry of Health has assured the forprofit nursing home industry that funding for homes for the aged and nursing homes will be equalized this year. We are absolutely and vehemently opposed to this funding plan. It will further entrench and enrich commercial nursing homes at the expense of homes for the aged. We need an immediate conversion strategy to turn for-profit nursing homes into publicly owned, not-for-profit homes, not a policy that makes the commercial sector even more viable.

The serious problems with the underfunding of the entire health care system are mirrored in Bill 101. In recent years, the financial contribution by the provincial government for long-term care facilities has not kept pace with the increasing demand. We will need to see more money, not less, infused into long-term care. But the bill does not include any adequate funding commitment from the province and, worse still, as we've mentioned, it shifts dollars from the non-profit sector to the for-profit commercial sector.

We do not believe that health care should be structured for the benefit of private entrepreneurs. We also believe that the service provided by the for-profit care centre is actually inferior. Through long and bitter experience, we have found that the quality of care in for-profit nursing homes is generally inferior, as are workers' wages, benefits and working conditions. There are so many examples of residents and staff in for-profit nursing homes being mistreated that we would have to devote an entire brief to this issue alone. We do not want to paint all the for-profits with the same brush. Some commercial homes do a good job. Some of the smaller mom-and-pop operations went into health care because of a genuine interest in the care part of their operation. But things changed when the corporate chains started gobbling up these smaller homes. In our view, inadequate health care is not the exception in these homes: it has now become the rule.

A few years ago, one nursing home decided to lay off a large number of health care aides and turned the home into a GM-style operation, a health care assembly line. Night shift workers were told to wake up patients at 5 am to get them dressed and ready for breakfast. The staff, who had always given full sponge baths each morning to residents who couldn't walk, were given new instructions. They were ordered to wash only the hands and faces of the residents. Other areas were to be washed "only if required," whatever that meant. And to save even more time, the brilliant administrator ordered the staff to reduce the distribution of medication from four times per day to twice a day. Consequently, some residents began receiving double doses of their medication.

The commercial system also lends itself to the maltreatment of paid staff. CUPE has taken legal action against nursing home owners for retroactive pay that was freely negotiated or arbitrated and for the misuse of pension funds. For example, one nursing home chain owes the nursing homes' and related industries' pension plan between \$400,000 and \$500,000 in employer and employee contributions. The owners have deducted these moneys from the employees' paycheques, but have refused to send them to the plan.

There's also a problem with private nursing homes in that they are not monitored correctly. We believe the private nursing home industry in Ontario has not been adequately monitored or properly held accountable for the considerable revenues it obtains from residents and the provincial government.

In 1988, the Ministry of Health residential services branch changed its system of inspection from one based on enforcement to one based on consultation. The net effect has been to allow private nursing homes to remain largely unaccountable for the services they provide, except during the pre-announced annual inspections conducted by the ministry.

We've pointed out some flaws in that system and would like to reiterate them here today.

The 1990 Provincial Auditor's report pointed out the flaws in the current inspection and compliance system. Here are some of the findings:

- Over 40% of homes did not receive any visits in addition to the annual licence renewal. Additional visits are important to ensure standards are met throughout the year.
- Homes were not being referred to the enforcement section for further monitoring and investigation.
- Long advance notice of licence renewal reviews could allow a substandard home to temporarily comply with requirements.

Our experience with the new compliance system is that it fails as an approach. For example, in 1984, 20 homes were charged, 497 charges were laid and 117 convictions resulted. In 1989, a year after the ministry changed its system of inspection, zero homes were charged, zero charges were laid, and obviously there were no convictions.

What we need are tougher rules. This situation cannot be allowed to continue. If the regulations are not tough enough, they then must be toughened up and they must be enforced. Ministry contacts told CUPE that the Nursing Homes Act and regulations are not fully enforceable as a result of previous court decisions.

These technicalities do not let the ministry off the hook. If the act requires amendments, this should be rectified as soon as possible. We have already wasted too many years dealing with a toothless piece of legislation.

Some briefs submitted to the standing committee have expressed concern about the expensive bureaucracy they think will result from the enhanced inspection and enforcement mechanisms. We strongly disagree. The provincial government has a responsibility to ensure that its funds are being spent wisely and that resident care conforms to provincial standards.

We can see why some homes would resist this change. They like the status quo, because under the current system of compliance, they are not being held accountable. Without a strong enforcement mechanism, inspections were nothing to fear. Now that they will be forced to conform to prescribed standards, they are worried. In our opinion, this is a good sign. It means the government is on the right track.

CUPE strongly supports the posting of service contracts in each home. At long last, both residents and staff will be able to know what services the home is expected to provide and thus will be able to ensure that these expectations are fulfilled.

An important element, of course, in the enforcement is the ability of the employees to bring forward concerns, and we believe we need whistle-blowing protection. If the government is really serious about ensuring that standards and facilities are adequate and that residents are receiving the proper levels of care, then it also must incorporate whistle-blowing protection into the bill.

It is the residents and staff who can monitor a service agreement better than anyone else. It is therefore essential that they be legally protected from any owner reprisals and, further, that they accompany the all too infrequent inspection tours.

It is clear that the ministry is not up to policing infractions. We have seen ample evidence of this time and again. Ministry officials are not the ones forced to live their lives daily with substandard and often dangerous conditions. Residents and employees are the very people who are not only knowledgeable but have the greatest stake in well-run nursing homes and homes for the aged.

In terms of the placement coordinators, in theory, at least, there is something positive to be said about the role of placement coordinators in bringing some order to the system. However, in the reality of declining institutional care and the completely inadequate supply of non-profit beds in the system, there is a real risk that the placement coordinators will become nothing more than the foot soldiers of government policy, marshalling the elderly back into their homes and apartments because there is nothing available in long-term care facilities.

We don't want the placement coordinator function to exist simply to do the government's dirty work. The government must address the fundamental inefficiencies in the system and must ensure that more non-profit beds are opened up for people who need and want them.

The appeal process outlined in the bill is completely inadequate as a dispute resolution mechanism. It's not one that is going to be either effective or fair to an elderly person who isn't happy with his or her placement or, probably more to the point, lack of it.

People are often not happy in the facilities in which they find themselves. They want to get out of a bad situation and they want to get out fast. They don't want to wait several months or more, and they certainly don't want to have to go to court and take on a government bureaucracy.

We think the process outlined is an inappropriate use of government power wielded against a single citizen. It represents the worst approach to resolving conflict. That heavy-handedness is also apparent in that it allows one single member of the appeal board to constitute a quorum.

We believe this entire section of the bill must be thoroughly redrafted. It must be redrafted in the context of more non-profit beds being opened up and, more specifically, must spell out to the consumers their choices of where they may want to live, and what kind of facility must at all times be taken into account.

As it stands now, this section of the bill appears to have more in common with an axe that can be held over the head of an elderly person than a tool to assist them.

We would like to highlight some areas where we believe waste is apparent in the system. We have outlined some of the problems with Bill 101 and with the overall plan to restructure long-term care. All these shifts and redirections are taking place because of money, or rather, lack of it.

While the government pleads poverty as an excuse for cutting services and boosting fees, the Health ministry is virtually tossing cash out the window. Sadly, it shows no interest in cutting the extraordinary waste that robs money from vital services.

There are plenty of opportunities for substantial savings. The most obvious, of course, is to eliminate the for-profit service so that health care dollars go into health care rather than corporate bank accounts.

I'd like to highlight here what happens to taxpayers' money when profit is involved. CUPE believes there's an inherent conflict between profit-making and quality of care. We have argued this point time and again with commercial nursing home operators and with key bureaucrats in the Ministry of Health. Each time we opposed the equalized funding scheme for nursing homes and homes for the aged, the commercial owners said a discrepancy in care between the two types of homes was because of the difference in funding. That's simply not true. A nursing home's desire for profit ultimately affects how it spends more money, no matter how much it receives from the government.

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In fact, the Ministry of Health has proven this by its own study of the form 7s. Form 7s are the audited financial statements that nursing homes are required to send into the ministry each year. Attached to the end of the brief is a Ministry of Health document entitled Summary of Form 7s. As you know, about 11% of the nursing homes are non-profit; the remainder are for-profit. If you look at page 10 of appendix 1, you will see that the total revenue column indicates that in 1990 and 1991, total revenues were slightly higher in the for-profit homes than in the non-profit homes; 3.8% higher in 1990 and 3.5% higher in 1991.

But when it comes to the expenditures side, these are the startling conclusions that CUPE found:

Salaries and wages: Non-profit homes spent, on average, 8% more on salaries and wages in 1990 and 11.2% more than for-profit nursing homes in 1991. This is a positive development, since the average nursing home worker earns considerably less than a chronic care hospital worker, although their work is almost identical.

Resident care expenditures: We added up the following line items: continence care products, medical and nursing supplies, raw food costs, dietary supplies and services, housekeeping supplies and services, and laundry and linen supplies and services. On an average per diem basis, the non-profit nursing homes spent 37.3% more than the forprofits on these resident care items in 1990. In 1991, the non-profit homes spent 42.2% more on these products and services. So this should tell the standing committee where the priorities of the non-profit home lies.

Indirect expenses: This is where the commercial nursing homes are spending excessive amounts of money. On items such as management fees, consulting and professional fees, rent, mortgage interest, other interest, depreciation and other expenses, the for-profit homes spent 60.3% more than non-profit homes in 1990 and a whopping 65.8% more in 1991.

It is quite clear that for-profit and non-profit homes have different funding priorities. Non-profits put more money into resident care and salaries, while for-profits funnel a significantly higher proportion of their revenues into so-called indirect expenses. Let us be clear: This is how they're making their profits.

There are some other interesting points you might like to know. If nursing homes are claiming depreciation costs at 2.6%, as stated in 1991, and have been receiving tax relief for these costs, why are there between 10,000 and 14,000 beds in non-compliance in the province? Have the for-profit

nursing homes used depreciation as a tax haven without spending these resources on upgrading their facilities?

These homes have claimed depreciation as a loss. We wonder if it is only a paper loss, which the rest of the taxpaying public has subsidized for many years, over and above the considerable revenues the homes receive from the provincial government.

We'd also like to address the question of corporate concentration of the nursing home sector. In 1991, 62.8% of the nursing home beds were owned by corporate chains. The breakdown of revenue and expenditures by ownership type, group-owned versus single-owned, is listed on page 11. We would like to point out that nursing home chains are even less cost-effective than their single-owned counterparts.

One would have thought that owning several homes would reduce the indirect expenses on a per capita basis, since a nursing home chain could presumably operate with the benefits of economy of scale. Unfortunately, the facts point to a completely different financial dynamic. Nursing home chains spent 24% more than single homes on indirect expenses in 1991. We wonder if parent companies are engaged in some form of transfer pricing by charging excessive amounts of rent, mortgage interest and management fees as a way to hide profits.

We are not clear where the money is going, but we would like the standing committee to recommend that the provincial government request the full disclosure of this financial information in the interest of the residents and the taxpayers of Ontario who are funding these operations.

Finally, if the commercial nursing homes are paying so much mortgage interest, we suspect their capital investments in these homes are minimal at best. Highly leveraged mortgages funded out of these per diems could easily be transferred to municipalities or non-profit societies. After all, it is clear that the banks and mortgage companies are in fact the real owners of these facilities. Surely, it would be in the public's interest for these moneys to be spent on resident care rather than on so-called indirect expenses.

Based on this evidence, we urge the standing committee to recommend that the government transfer commercial nursing homes to the municipal or not-for-profit sector.

Until the transfer is complete, we further urge the committee to recommend that the proposed equalization of funding between nursing homes and homes for the aged be postponed until expenditure directives are put in place requiring all for-profit homes to spend a minimum amount on all residents' supplies and services and on salaries and wages.

Strict limits should also be placed on the amount nursing homes may spend on indirect expenses.

If you step back and take a look at what's happening to health care workers, the picture is pretty grim: 1,500 to 2,000 jobs are going to be lost in homes for the aged due to the changes in the government's funding plan for long-term care facilities. Add to this the more than 3,000 hospital jobs that are disappearing due to this so-called reform and you get some idea of the enormous changes taking place in our health care system.

The people we are losing are irreplaceable. They are the very people with the training, experience and expertise needed in any reformed system. All the health care restructuring currently taking place is doomed to failure if one of the most important parts of the system—the workers who are the skilled, front-line people—are simply thrown out.

That's why we want job guarantees. We think laid-off hospital and homes workers in one part of the system must be given first crack if jobs open up in another part, and we want those workers to be paid at their equivalent salary levels. You can't have it both ways. If you want stable service delivered by experienced workers, you have to pay for them and you have to pay them what they're worth. Otherwise, we'll continue to see high turnover rates and unskilled people delivering crucial care.

In conclusion, a major assault is being launched against working people in this province and in this country. It's orchestrated by the federal Tories who have cut billions of dollars in cash transfers to Ontario for health and education.

Sadly enough, it's being enforced and assisted by a government that should know better. With good reason, we are beginning to lose confidence in the ability of the provincial government to take on the huge task of restructuring our health care system on its own. To do this effectively requires health care unions and consumers to be involved at the highest level of decision-making.

Former Health minister Frances Lankin agreed unions needed to be more formally involved in the decision-making process and this is how we would propose doing that: a guarantee of health care union representation on district health councils, equal representation on the Joint Provincial Planning Committee, currently made up of government and Ontario Hospital Association reps, and regular monthly consultation meetings of health care unions with the Minister of Health.

I would like to bring my remarks to a close now and thank you for your attention. I would just like to point out that a full summary of our recommendations is included at the back of our brief and we ask that you consider them carefully. If there are any questions, I would be happy to answer them. Thank you.

The Chair: Thank you very much for your presentation and for the document and attachments you've provided us all with.

I'm afraid our half-hour is complete. We began at 10 after, on my watch here. I'm in the hands of the committee, but the problem is that we started late and I think we're going to have to bring this presentation to a close, unless members—I regret it's a very—

Mr Larry O'Connor (Durham-York): Perhaps one round, one question each—maybe short.

The Chair: I'm just concerned about our time. We are late and we're going to be late and we have a very full day. I think there's plenty of material in here as well as in the presentation, and I want to thank you for coming before the committee today.

Mr Ryan: Thank you.

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CANADIAN AUTO WORKERS, LOCAL 40

The Chair: If I could then call on the representatives from the Canadian Auto Workers, Local 40. Welcome to the committee this morning; we're glad to have you. Would you be good enough to introduce yourselves, and if I could just note that if you would like some questions we could allow a little time. We have half an hour from when you begin but, in fairness to others, I'm afraid we have to keep to that schedule. So, please introduce yourselves and then go ahead.

Ms Laurell Ritchie: We will be placing our comments in writing and getting them to the committee within the next few days.

I would like to just take the opportunity to introduce myself, Laurell Ritchie from Local 40, Leo Robinson and Gloria Edwards, who work at Nucleus Housing, and Sue O'Brien, who works at Participation Apartments. As well, we have Irene Millar, Marjorie Stuart and Tony Sewell, who also work in these projects.

First of all, happy International Women's Day, and we hope you will keep this in mind as we make some of our comments. Frances Lankin, as Minister of Health, has already been quoted some while ago. We want to quote another statement that was made: "We've got one last chance to reform the long-term care system, so we better do it right. That's why we're here: because we don't think it's being done right. We are here to address the specific concerns of our members in five of the province's support service living unit programs, better known as SSLUs. We favour some reforms in this system, where it makes sense and does not reinvent the wheel, but with the current initiatives, we see some potential for disaster.

The government's 1991 consultation paper called SSLUs "a very successful example of supportive housing for adults with disabilities. The projects are cost-efficient, providing support care staff in each building who are available around the clock. The underlying philosophy is one of independent living with a high degree of self-directed care for these disabled adults. There is a total now only of 1,000 designated SSLU apartment units spread throughout a number of apartment buildings in Ontario.

In Metro Toronto, where our members work, there is a total of 270 such units. The official waiting list in Toronto includes some 976 disabled adults. This is actually a remarkably large number, given that the existence of these projects is not widely advertised or known. Notably, more disabled women have been accessing SSLUs in recent years. These projects are already popular and working well as a community-based middle option between what is called institutional care and, at the other end, isolated living situations on one's own or with one's family.

As workers at the ground level, the delivery end of the system, our members are witness to the real-life consequences of the government's long-term care agenda as it appears to be unfolding. We are not here to talk about theories but to talk about what is actually happening or beginning to happen to human beings and to an SSLU system that was operating effectively.

Support care workers, the majority of whom are women and workers of colour, are most certainly concerned about their jobs and working conditions, and they have every right to voice those concerns. What some may not appreciate is the complexity of their concern and the insights that can be gained from their recent experiences. Some entered this field of work because of a special interest or predisposition in services for the disabled in our communities; others grew to appreciate the concerns of disabled adults as they went about their day-to-day work with them, providing a physical and emotional support system. Finally, most of our members are also concerned because, perhaps more than most, they realize how quickly one's life can change if oneself or a family member becomes disabled, and of course they know that most of us will confront the issue of care in our own old age. So long-term care is a subject matter close at hand.

Bill 101 can be fairly characterized as a technical piece of legislation, one that reflects the intended overall redirection of long-term care but which also denies us an opportunity to debate the guts of that redirection. What is clear, however, is that Bill 101 does reflect a move to commercialization and privatization. It gives a green light to a shift of public dollars from non-profit services to the profitmaking commercial nursing homes. Such a shift will inevitably infect the provision of other services, including SSLUs. SSLUs cannot ultimately be quarantined from this rationale. As time goes by, the rationale used in one service area will be cited by those looking to turn a private profit in another sector.

We also want to ask whether legislators have forgotten to take into account what this could mean in the context of a North American free trade agreement, with its extension of investment codes and the right of national treatment for foreign firms in its expanded term for services. This is all the more so given the new disciplines under the proposed NAFTA on provinces. We need only think of the problems with what I think we would call the rapacious greed of some of the giant US enterprises in the private health care sector to begin to appreciate some potential problems there.

We also challenge the shift of dollars to the private profit-making sector because it represents an unnecessary burden on the public purse. Why should any part of our health and social service dollars go into private pockets?

We also want to talk about the failure to ensure decent funding. We see no commitment in Bill 101 to provide reliable and decent levels of funding for the very successful support service living unit programs or any other service area covered by the bill. In fact, the very future of what the government called a very successful model is in jeopardy with the funding cutbacks.

With the funding cutbacks, it is difficult to imagine anyone calling SSLU a success story for much longer. The joint ministries of Comsoc, Health and Housing have gotten away, to a considerable extent, with describing SSLU funding, for the next two fiscal years, as a freeze. The reality is very different. Many projects built up their services and numbers of disabled-tenant units on a budget that incorporated both a base budget and, for many years now, a so-called special one-time funding budget.

The base budget is indeed frozen, but on the other hand, the special funding is being deleted in its entirety. Accordingly, cutbacks in services which already have many constraints on them must occur. Even now services are strained, as we witness a disproportionate number of high-care tenants moving into SSLUs, presumably on the government's assumption that those with lower care needs should simply stay where they are.

We want to look here at two of these projects, both Trimbee Court and Humberview Co-op, which are administered through Nucleus Housing Because these are nonprofit projects, about 85% to 90% of labour costs are associated with support-care staffing, so the only real place to cut back, of course, is in those labour costs. Specifically, at Nucleus Housing, as of April 1, just a few weeks from now, we are told that some 7,500 service hours must be trimmed from the services that are available there. That means cutbacks in staffing complement, which in turn means that the disabled tenants—they have expressed this themselves in letters to the government, and some already are undergoing reduction in their meal-time service booking times—face the prospect of getting up at 4 am or 5 am instead of 6 am or 7 am in order to arrive at work, because many of these people do have jobs. In independent living situations that is a possibility, but as disabled people they already have long days of 12 hours, because what takes you or me perhaps five minutes takes a disabled adult much longer. With those extensions, the 12-hour day becomes a 16-hour day or more. It has impacts on health and it certainly has impacts on the social and family lives of these persons.

It also means reductions in personal care. Treatment times—for example, bowel and bladder treatments and procedures—must be fitted into available staff hours, as opposed to being self-directed. It will reduce the times when they can call for non-booked time assistance from staff, either for emergencies or for other forms of assistance that are given. It will reduce the washing and hygiene times. This not only compromises the health and safety of disabled tenants; it potentially jeopardizes their jobs if they are late for work, and in general, forces them to fit their lives into an extremely regimented existence.

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In short, SSLUs would appear to be on their way to becoming mini-institutions, the exact opposite of what was intended by the deinstitutionalized option for disabled adults. This would be a sad day. If anything, the supportive housing model is one that should be expanded upon, not only for the disabled in our community but for seniors looking for options other than living in isolated apartments or moving into nursing homes. We note that the CAW retired workers' executive submission of March 1992 in speaking about seniors said, "It is the physical structure of particular institutions that needs to be examined. Our question would be: Could a chronic care bed not be delivered under the roof of a group home seniors' apartment or a retirement community? We think this is one such model that would address that. However, having said that, there is no point in extending an already underfunded system; and that's where it is.

For support care workers in these projects, the redirection agenda sets the stage for-and we're already beginning to witness this because April 1 is rolling around and the agenda is being laid out for us in meetings with management and boards, often made up of tenants as well as outside administration. We're confronting, as I said, already or down-the-line layoffs, reduced shift hours for part-timers. In the case of Nucleus, anybody working less than 40 hours a week is considered part-time. If you want to work 38 hours a week, you're part-time, and those people are being hit with reduced shift hours: fewer shifts on a schedule-again for those who are classified as part-time; swing shifts, working an evening shift and moving on to a day shift the next day these are not things that were happening before; speedups, as they move between shorter booking times between apartments, increasing stress and the chance of injury, particularly back injury, where they do lifts of disabled tenants who in turn will risk falls and injury.

Cuts in benefits: This we believe was never dealt with properly or addressed properly in looking at funding. The reason the cuts in benefits are on the horizon is because private insurance companies are significantly increasing their premiums, and I mean significantly, in part to match the phenomenal growth in prescription costs occasioned by the recent federal drug patent legislation, to be made worse with the more recent legislation passed there, and dental charges under the Ontario Dental Association's fee guide.

We see as well the erosion of pay, not only because people will be and are working reduced hours and other forms of remuneration, because if you're not full-time, you're a part-timer and part-timers do not have benefit coverage and more are falling into the category of part-time. We see housekeepers being told that their rates of pay, which are far from healthy, must now begin to compete with the homemakers: may face the prospect of competition with the homemakers' associations where people are earning \$7 to \$8 an hour. These are the same women as housekeepers in these projects, who just recently tackled the problem of these traditional female job ghettos to get equal pay for work of equal value; and we'll use the legislation there to achieve that.

On a more ironic note, these are the same workers whom the government has recognized in recent years as being underpaid in comparison to similar work being done in institutions and went through phase 1 and 2 upward adjustments to those rates. Phase 3 never developed. I say "ironic" because this was the money they used to call the beer money. We never saw phase 3.

A stressful work environment is the other prospect here. As we have read the government's redirection plans, the prospect of having an Alzheimer's patient in one apartment in the building and a spinal cord injury victim in another is not a prospect for anything other than more and more stress. Here we also face the problem of displacement, quite frankly, by those RNAs who are being squeezed out of hospitals and into institutional settings and who now have to register with the health training and adjustment board presumably to move into the kinds of projects where our members work, and with that goes an increase in standards but based on a health model. A lot more discussion

has to happen on this particular model being enforced within SSLUs because we don't think it's appropriate in all circumstances. It's extremely time-consuming and costly for a lot of our members to look at the prospect of retraining to meet these so-called standards that are being talked about. It's going to be especially hard on the women, who typically have less formal schooling although most have done this job for many years and quite successfully. We have tried to get in on the reference group that is looking at this issue, but we are told that now there are 29, 30 members of this committee and the doors are closed; there will be no others brought in to participate in the committee's deliberations on standards. So we have that fear.

Finally, we have concerns about the placement coordinators and service coordination agencies and the powers that would be vested in these coordinators, subject, of course, to a costly and time-consuming appeal procedure. We believe that this is going to present considerable problems for those in SSLUs or trying to access SSLUs. The community boards are certainly highly politicized and have a traditional bias to those parts of the sector that are based on the health model.

To close, we want to suggest, and we will attach it to our final document, that an examination be given of some of the data on waiting lists now for SSLUs. The one we have is for the Metropolitan Toronto area, and some of the things are quite fascinating. For example, as a total, the largest group seeking entry into SSLUs is those disabled adults currently living with their parents or their spouse or other adult. In other words, the idea that everybody wants to or should be living in a home environment is not one that is shared by all those in the disabled community. We also find in these numbers that there are those who are disabled and senior, and we also find a large grouping of those who are at the young adult level who are obviously seeking some privacy and dignity to operate on their own in a supportive community.

In summary, we think the direction things seem to be headed in flies in the face of the much-touted phrases about care and service and choices. As workers and as citizens, we don't think the choices we see are real choices at all: institutions with fewer spaces, community-based projects like SSLUs with inadequate funding, home care with stressed-out older parents, primarily mothers, to provide 24-hour care, or highly privatized outreach services to isolated dwellings with all the problems that entails. We believe that in some cases the wheel is being reinvented and that in other cases, where reforms are needed, the cart is being put before the horse. Certainly municipalities agree with us on that one. In a time of economic crisis, the last thing we need to do is repeat the experience of the deinstitutionalization of psychiatric patients. That is where we see things headed and we're very upset and very angry, because we're facing this day in, day out, even as of the last few weeks.

The Chair: Thank you very much for your presentation, and as you indicated, we'll circulate a copy of your remarks when you send it in, but of course we have it on Hansard in terms of what was said this morning. We do have some time for questions.

1100

Ms Jenny Carter (Peterborough): I certainly appreciated your presentation. It was a rather different emphasis to most that we've had. I particularly appreciated your mention of NAFTA, which I think could be a factor we would have to look at in the field of privatization and the general situation.

We had a presentation from a gentleman who I believe was living in an SSLU. He referred to something you didn't mention, and that is that the act provides for direct funding for people to hire their own care providers. He was suggesting that if there were suitable accommodation for disabled people to move to and funds to hire their own care providers, then there are people in SSLUs who would be ready to leave them and move to a more independent lifestyle. I just wondered what your comments might be on that.

Ms Ritchie: Others of our delegation may want to comment on that, but that's a subject that has been discussed with management. Some of the tenants are also on the board that constitutes management. I would say that we come at this one from a different approach than the tenants who are part of the management situation. As we listen to them, quite frankly, I suppose we might characterize it as somewhat naïve. I think that from what we've heard in those discussions, a lot of the disabled tenants we're talking about have the idea that somebody is going to give them a pile of money and that they will be able to hire what amounts to a full-time companion. We have had discussions before.

We've already seen problems in the discussion of these so-called outreach projects. First of all, right off, we had problems because management, in talking about experimenting with these outreach projects, which is more or less what you're talking about, said that the problem with having the labour contract collective agreement apply was that the collective agreement provides for a minimum of four hours' call-in pay, either work or pay for four hours. They said that under an outreach program they couldn't possibly guarantee that anybody would get four hours' work or four hours' pay.

In general, I think the problem is that somebody somewhere has encouraged them to think they're going to have 24-hour companion care. I don't know whether somebody wants to reveal the name—I won't suggest it myself—but we know that there are already people who operate outreach projects on these private models who are saying—well, you used the phrase.

Mr Leo Robinson: Yes. Actually, what he says is that if someone's got a bowel accident or something like that, he might have to wait for quite a few hours before he could get somebody to come and take care of him.

Ms Carter: I think people—

The Chair: I'm sorry, Ms Carter; I'm afraid we're tight for time. I'm going to have to move on. Ms O'Neill, last question.

Mrs Yvonne O'Neill (Ottawa-Rideau): I really thank you for coming this morning. I've felt from the beginning of these hearings—and I've been here since day one—that the disabled have not had the profile they needed in this.

The whole basis was just on this direct funding, which we don't know very much about. I would like you to say a little bit more about your recent problems regarding the deletion of the special funding and the service hours, because we've had one witness in Windsor who talked to us a little bit about her own personal experience, a disabled individual, but we haven't certainly had what you seem to be suggesting is a real trend, so could you say a little bit about what kind of messages you're getting and, if you want to, who you're getting them from?

Ms Gloria Edwards: I work in SSLU Nucleus Housing and, as my colleague was saying, if they have an outreach and they have an accident, they will have to wait a couple of hours. In the SSLU with 24-hour care, if you have an accident, you can call someone on the pager, on the phone and they'll be there in a matter of minutes to take care of you. That's where you're dignity is concerned. No one wants to lie around in a mess or be dirty or anything like that.

The thing is that the care is one on one. They may be disabled but their mind is not disabled. They can tell you what they want. You do not have to go by a paper that you do this or you do that. You learn about this person. You grow to care about these persons, their likes and dislikes, how they like their hair, how they like to dress, what scent they like, what foods they like, and you go along with that.

Taking this away from them is like throwing them right back where they wanted to get away from, to come into community living.

When you cut their service hours, it's like going back and saying, "You have to do this," and they have no choice in saying that. "I want to get up at 6 o'clock." You say, "Due to service cuts, you have to get up at 4 o'clock." There's no choice.

Mrs O'Neill: What about the special funding? What does it cover?

Ms Edwards: Basically, what's been happening for the last number of years is that it's one of those things where there was a category called special one-time funding, but it got carried year after year after year and got worked into the budgeting for the projects. They took on new units. They took on staff to go with those increased units and so on. Now the word out there is there's a freeze, but as much of a problem as that would be, that is not the whole story because a significant segment of that budget is being withdrawn. There will be no more of the special one-time funding.

Part of what has been treated by these projects—and not just the ones we're representing—has been treated as part of the regular budget. I'm not going to comment on the advisability of having gone that long in that way, but at this point, the only real resolution of that is to incorporate into what is the base budget.

Otherwise, those units are at risk, and certainly if the service hours of those units aren't cut out of the system, then the only option is to reduce the service hours. We've just gotten faxed copies of new schedules even as of Friday. It's one of the reasons this is not all typed up, because we're battling now on these fronts with people being moved on to swing shifts, having their hours cut, and that

includes many women who are single parents or whose income is very crucial to the family. Their hours are getting cut. There's more than one side to this.

Ms Sue O'Brien: It also meant 1% increase in our wages last year. We're talking zero this year and zero next year. It's affecting quality of service, quality of living on both fronts, for clients and for people in the workforce. Choices are very limited and I appreciate your comment in terms of there's not enough said about this sector. It really needs to be talked more about before pushing through all this legislation. We need to be heard to be able to express our concerns on both sides.

Mrs O'Neill: I thank you for your perspective.

The Chair: Thank you very much. I apologize that we're out of time. Just on a personal note, having paid a visit to Nucleus Housing, I think at the Humberview Lodge, I was very impressed with all the work that was being done there. I wish you all the best in the future. Thanks, again, for coming.

Ms Ritchie: We could do with some more beer money.

The Chair: I had a feeling that wasn't just for entertainment.

The Chair: I'd like to call our next witness, the Victorian Order of Nurses, Metropolitan Toronto branch. As we get organized here, we have to get a few wires set up, so we'll just get that done or perhaps it's already been done.

Mrs Barbara Sullivan (Halton Centre): Mr Chair, while that's being done, I wonder if I could ask if ministry officials would provide us with a clarification of changes in funding for the SSLUs. I think that would be useful.

The Chair: We'll note that request and get that information.

Mrs O'Neill: If I might just add to that, particularly the special funding component of it, if that could be broken out over the last three to five years, that will be very helpful.

The Chair: All right, fine. In order to get all our technology straight, we're going to need a one-minute recess, I've just been informed. So if everybody wants to take a one-minute recess, so stretch, get a cup of coffee and we stand recessed for one minute.

The committee recessed at 1112 and resumed at 1113.

VICTORIAN ORDER OF NURSES, METROPOLITAN TORONTO BRANCH

The Chair: We'll now reconvene. Perhaps I might first of all say welcome to the VON, Metropolitan Toronto. As we have said on many occasions to other VON representatives, we appreciate what I guess I would call a full-force frontal involvement in this committee. We have found it extremely useful and we welcome you here today. Perhaps you would be good enough, first of all, just to introduce yourselves before beginning the presentation.

Ms Vicki Wootton: First of all—can you hear me?—we'd like to thank you for inviting us to make the presentation. Deborah Simon is director of client services for VON Metro. Barbara MacKenzie is the executive director

of VON Metro Toronto. I'm Vicki Wootton. I'm a member of the board.

As you say, many VON branches in VON Ontario have made submissions to this committee, and so as not to wear out our welcome, because there are more coming—I looked at your agenda—we would like to focus on those concerns that we would like highlighted.

First of all, though, I'd like to tell you a little bit about VON Metro, just a quick summary of who we are. We were one of the original branches established in 1897. We're the largest non-profit nursing agency in Canada and certainly the largest one necessarily in Metropolitan Toronto. We also serve the largest, most diverse area in Canada—six cities—and last year we made something like 500,000 visits to clients

The kinds of services we have are the visiting nursing program, where we provide both acute services and long-term care or chronic services, shift nursing, that is, for people who would normally be in the hospital for some circumstances, but we're able to look after them in the home because of shift with our volunteer visiting program, and a big component of that is palliative care visiting. We have dieticians on staff as well to provide service.

We have specialized expertise in a number of areas including maternal and child health, palliative care, enterostomal therapy and so on.

VON has a number of partners. Our biggest partner is Home Care Program of Metropolitan Toronto. We are a major provider for that agency. We're also in partnership with the United Way and many of its agencies. There are universities, colleges and high schools, and by that we provide placements for students, medical students, nursing students, RNAs, so they get a good taste of what it's like to work in the community and look at the other side of that. We've been doing that for a long time.

We work in partnership with hospitals. Much of the move to deinstitutionalize some of the procedures and the length of stay in hospitals is because agencies like VON are able to pick up a lot of that work and provide it in the community, provide the care. We work with long-term care facilities as more and more of their clients are at the other end of the spectrum where they require heavier care. VON works in partnership with these agencies to work with the nurses and the aides to perhaps show them how to start IVs, if that's going to be done, or to provide heavier care requirements. As well, we work with other community agencies and providers.

Our most important partners, however, are our patients and their families. The goal of VON Metro nurses is to get those patients back on their feet and get them taking some kind of responsibility for their own health and wellbeing, so the partnership is very, very important with the patient and family.

Being a community-based agency with nurses right in the community is quite a challenge. We're working in extremes. Our nurses might look after a newborn baby and mother; on the other hand, they look after a sizeable number of senior citizens to help them manage in the home. We cover the whole gamut of health status. Health promotion is a very important component, but we also do palliative

care for terminally ill patients. The site of service can be in a very affluent neighbourhood with single residential homes, or it can be in a high-density, publicly subsidized housing unit.

Also, we have an extreme volatility in the service demand. We can be asked to provide service within one or two hours or will provide service on a planned schedule basis, and that requires a lot of responsiveness.

One story that we're very proud of: A few weeks ago, we had a gentleman call on a Friday morning. He wanted a nurse to go to Poland and pick up his father and bring him home. The father required someone to accompany him on the plane. This gentleman had tried quite a few agencies. He got to VON. Within two hours we were able to find, first of all, a nurse who was willing to go to Poland on the weekend, which was extra time for her; second of all, one who could speak Polish; and third, one whose passport was up to date. In three or four hours we were able to provide that service. Now, I call that very, very responsive.

Our staff and our volunteers, as I said, have worked in the most ethnically, culturally and racially diverse area in Canada and our staff speak something like 36 languages, so we're able to provide quite a bit of service that is culturally and linguistically sensitive.

We are also a very responsible, accountable provider. While the legislation before us does address quality assurance, VON has had that in place for a long time—many, many years. We're not into a quality management framework that guides all of our service delivery and our management activities. We have a very well defined strategic plan that's updated regularly, and different strategies and objectives are tied into our annual budget. We know exactly where we are in any kind of endeavour.

Our board members and staff have all participated in multicultural, anti-racist training and, as well, we've been fully part of long-term care redirections since its inception.

We feel that there are a lot of strong points in Bill 101. First of all, we applaud the fact that it initiates standardization of long-term care facility legislation. That's long overdue and we support that. It also promotes a more coordinated access to services. It enhances accountability and quality assurance and introduces a uniform method of funding. Again, we do support that direction. It empowers people with disabilities and it also attempts to control unreasonable or excessive costs.

We do have some concerns, however. Our concerns all come around the issue of choice and consumer control. We support the right of the consumer or the consumer's surrogate to choose the site of service. An institutional site is not always the site of preference for the consumer. Some people require that services in the home would be more in keeping with what's right for them and we would like to see that addressed, that people have a choice of where they want to be cared for.

Another major issue is the facility of choice. This is of paramount importance, particularly in an area such as ours where we do have a large number of people from different races and backgrounds. Picture, if you will, yourself, supposing you were to go into a long-term care facility. You

don't speak the language that's the language of use in that facility. You're not used to the food; you don't understand the people, the other residents there; you're isolated from your family. You can see how lonely, isolated and frightened you would be if you were put in one of these facilities. Instead, what we're advocating is some choice in facility that will meet your needs.

Our other main comment and concern is that we believe the appeal mechanism must be much more timely and flexible. Supposing a person is already in a facility. We want to see the appeal mechanism kick in very, very quickly. You shouldn't have to wait a long time in a situation that you are uncomfortable in. We also believe that the facility's inspection process is rather prescribed, as opposed to consultative. We don't see chronic care facilities or rehab facilities included in this legislation and, overall, a lot of the changes are incremental rather than comprehensive.

In summary, we advocate for legislation that empowers the consumer, that promotes sensitivity to cultural, racial and ethnic diversity, particularly as it affects Metropolitan Toronto, and most of all, legislation that supports choice. We invite any questions you may have and we'd be happy to answer them. Thank you.

The Chair: Thank you very much for your presentation, and we'll move right to questions. Mrs Sullivan.

Mrs Sullivan: Thank you very much. I think all members of the committee have expressed their appreciation to the VON in various communities who have appeared before us, and I think one of the things that's been useful is that we've been able to see the diversity of operations of the VON across the province through presentations to us.

I'm interested in your written presentation. Under "Issues and Recommendations", just to follow on from what you've presented, where you indicate under section III a suggestion that would mean that financial boundaries or caps could be provided through a funding envelope for clients, how do you see that funding envelope working, directly with clients or directly through agencies? I'd like to hear more on that particular point.

Mrs Barbara MacKenzie: The reason we didn't give a lot of information on that was we understood that you had heard an awful lot of them from VON Ontario and that their presentation encompassed that.

We wanted you to understand that we don't think that services could be provided without some kind of financial constraints, because there are limitations. So we basically support the concept that VON Ontario presented, and that could be done by the consumer having the choice of determining whether, with the funds that are available, that service be provided in the community, and were there enough funds to support the services that they would require. Does that answer your question?

Mrs Sullivan: I think so, yes. I thought that we had another question here.

The other question I wanted to ask but which once again isn't in your presentation but moves one step past Bill 101, where we have the placement coordinator, looks towards the multiservice agency. One of the issues that is of some concern, certainly in my community, is that organizations

which have had a viable and strong community identification may lose that identification. Can you speak to that?

Mrs MacKenzie: That's a concern to VON in general and to VON Metro. The largest component of what we do is currently done through the Home Care Program; about 96% of what we do is through the Home Care Program. Currently, we have registered nurses, registered nursing assistants and dietitians as well as our volunteer component, but we don't have the homemakers or health care aides or generic workers, so we are still waiting with great anticipation and interest for the more definitive implementation plan that we're all expecting before the end of the month. We have been trying to—

Mr Jackson: The month?

Mrs MacKenzie: I guess we've been saying that for a few months.

However, we would like to be able to ensure that there is a place for VON. We feel very strongly that the part that VON has played in the community for a number of years is something that's valuable and shouldn't be lost. We feel that the enhanced value that our volunteers, both those who are involved in friendly visiting and palliative care visiting, as well as the involvement of the volunteer board of directors that we have, adds a great additional value to the community that could be lost if VON were not around as an organization as it is today.

Mr Jim Wilson (Simcoe West): Thank you very much for your presentation. I think any members who have ever had any dealings with the VON realize very quickly how important your services are to our own families and our constituents.

Because this is our last week of public hearings and during the break next week, which is March break, each of the caucuses will be putting together, and we've already begun to put together, amendments to this legislation, in your presentation you make a point that your branch has already adopted and has in place quality management practices. I'm wondering, on the page entitled "Issues and Recommendations" at point IV, you talk about Bill 101, that it's built on an adversarial-confrontational model rather than being consultative, if you can you expand on that, because we've heard that and I've asked many witnesses as we've been on the road during these hearings to give us some examples or ways we can improve the legislation to get some of this adversarialness out of it.

1130

Mrs MacKenzie: We also referenced the Woods Gordon study that was conducted in 1986, and I think many of the recommendations that were made in the Woods Gordon study could be helpful in looking at the consultative model rather than an adversarial-confrontational model. This was raised as an issue based on the segments of the legislation about the powers of inspectors, and it really is introducing a new inspection process to some types of facilities that haven't had that in the past and yet from a perception viewpoint have provided a good quality of care over the years.

I think that the quality management, if we look at identifying agreeable outcomes and have a consultant approach

looking at the outcomes and planning with facilities or providers, how they can improve the results, would lead to a better quality of care than an inspection or enforcement type of operation.

Mr Jim Wilson: I appreciate you reinforcing what many other groups have told us.

You mentioned in your oral presentation the need for a more timely and flexible appeal process. I was wondering if you had an opportunity to look at the eligibility criteria for admission that are contained in the draft manual and whether you had any comments on that, because while I think we can put some amendments forward that might improve the appeal process, I'm worried that we're looking at a very medical model and a model that says you have to exhaust all community-based services before you can be admitted to a facility. In my area of the province we don't even have the luxury of arguing about many of these community-based services; we simply don't have them that you may have in Metro, and if we didn't have the VON we'd have basically no in-home services at home. Do you want to just comment on that?

Mrs MacKenzie: I'm not familiar in great detail with the eligibility criteria, but I think that the recommendations we have made are around consumer choice. We'd like to see this be consumer-driven and feel that the consumer should be the one who is directing where his services are provided.

Mr Jim Wilson: Okay. We'll do our best there.

The Chair: Thank you. Mr Owens

Mr Stephen Owens (Scarborough Centre): On page 10, when you talk about the facilities inspection process being prescriptive, not negotiated: Could you explain that for me, or clarify it a little bit further?

Mrs MacKenzie: I think what we're talking about there is the same as the adversarial-confrontational model, where the inspector comes in, sees, gives reports, people will reply, is the same type of confrontational model rather than something that's negotiated looking at consumer outcomes and outcomes of care.

Mr Owens: I agree, having had some experience with the organization in Toronto in a former life, that your group has already done all the right things. In other presentations "total quality management" is the new managerial buzzphrase that is around—I guess it's the newest megatrends or in search of excellence book that's come out.

My concern, however, is that we've had some fairly spectacular examples of nursing homes that have been left to their own devices or have been involved in this internal responsibility process where things have broken down. When I look at the inspection process that's listed, I don't see it having an adverse effect—if VON, for instance, were running a facility and doing the good things that you're doing now, I don't see how that would have a negative effect. I would see that in some facilities where things aren't happening as they should.

I'm currently looking at a situation in my own riding where things have broken down—I would suggest fairly seriously—and we can't seem to get things done because we don't have the muscle or the teeth, whatever words you

would like to use to describe that. So how do you balance that, the good work that's going on in some homes versus the not-so-good work that's going on in other places?

Mrs MacKenzie: You're right, quality management is the latest buzzword, and I guess one of the things that we've tried to look at is, what is it that the consumers want and need, how well are we doing that and how can we do it better? As the consumers' needs change, we need to be responsive to those needs and we need to look continually at how we can better do that.

When we talk about prescriptive rather than negotiated, if all the effort that is put into a prescriptive or adversarial process could be directed towards making the improvements that the consumers—whether they're consumers in a nursing home, or homes for the aged, or other type of facility or in the community, if all of that could go towards trying to make things better, then perhaps the results would be better and meet the consumers' needs more appropriately, what they want.

The Chair: Thank you very much for coming before the committee today and making your presentation. We appreciate it.

Mrs MacKenzie: Thank you very much. We appreciate the opportunity.

The Chair: I would then call upon our final witness for this morning, the Canadian Federation of Independent Business. Just as we're waiting for that representative to come forward, could I indicate to committee members that the 2 o'clock group will be unable to come. What I would suggest would be that we start at 2:15. I suspect the 2:30 group would be here, and that would mean we could get through our afternoon with some dispatch. If I could also ask the members of the subcommittee if we could just meet very briefly at the end of this morning's session, I would appreciate it.

CANADIAN FEDERATION OF INDEPENDENT BUSINESS

The Chair: I want to welcome the Canadian Federation of Independent Business. If you would be good enough just to introduce yourself, then please go ahead with your presentation.

Mrs Pat Thompson: Good morning. My name is Pat Thompson. I'm associate director of research with the Canadian Federation of Independent Business. The Canadian Federation of Independent Business is a non-partisan, non-profit organization representing independently owned Canadian-operated enterprises across Canada.

On behalf of our 40,000 members who do business in the province of Ontario, including those who operate private nursing homes, we welcome the opportunity of presenting this statement on Bill 101, An Act to amend certain Acts concerning Long Term Care.

Mr Chairman and members of the committee, against the backdrop of the outright attack by the Ontario government on private-sector service providers in the province, the Premier of the province has now called for action on ballooning government debt. Just a week ago, after a meeting with the premiers of Saskatchewan and British Columbia,

Ontario Premier Bob Rae stated that, "Change must be the order of the day."

Now, the small business sector in Ontario applauds this sentiment. It is time for the Ontario government to drop its attack on private-sector service providers.

Mr Cameron Jackson (Burlington South): It's time for the government to change. I thought that's what you were going to say.

The Chair: Order, please.

Mr Jackson: Did Hansard get that, Mr Chairman, I hope?

Mrs Thompson: I shall continue.

It is a well-established fact that an aging population increases the demand for health care and related services and, furthermore, that the cost of this increased demand strains the resources of even the most successful economies. If the demand is to be met, it is essential to mobilize a full spectrum of care resources, drawing from both the private and the public sector and welding them into an efficient, flexible service catering to the changing needs of the elderly, within the means of the taxpayers.

1140

Let's look at the government's attack on private sector service providers. To date, the Ontario government's strategy with regard to the delivery of health and related services has been formulated without proper recognition of the vital role played by independent operators. Indeed, any participation in social care giving by the private sector appears to be anathema to this government. It is time for a change in direction.

In the case of child care, the government's strategy has been to eliminate the private sector centres and switch to a public sector child care system. In its child care reform public consultation paper of January 1992, the government stated its preference for developing the public sector. I quote: "Central to this effort will be non-profit services. We believe that the best way to use public funds to improve the quality of child care is to direct them to publicly accountable non-profit services."

The government subsequently backtracked on its contention that public sector child care equated with better quality care, an unjust claim which, central to their original strategy but not substantiated, was both challenged and overturned.

The document then made the ridiculous and wrongheaded statement that, "Child care, like health care and education, is simply too important to be left to the influence of market forces."

Meanwhile, the government announced that its first step in switching to a public sector child care system would cost taxpayers \$75 million without adding a single extra child care space.

Next, let's look at the long-term care issue. The Ontario government's public consultation paper on long-term care, which came out in October 1991, also laid heavy emphasis on the public sector, stressing that one of the government's goals was a "continued preference for a not-for-profit service delivery system of long-term care." This preference, confirmed by a speech by the minister in July

1992, would be given the power of law by Bill 101, which if enacted without amendment would set the scene for increased difficulties for private nursing homes.

The current maze of legislation concerning long-term care is confused by the existence of many discrepancies and anomalies and we therefore welcome the government's attempt in Bill 101 to develop the same set of regulations to treat all types of residential homes alike. However, as it stands, the provisions of the bill lead to considerable uncertainty on the part of private nursing homes on the role they can expect to be playing in the long-term care system of the future.

The proposed new service agreement system is central to the new approach. However, since service agreements must be renewed every year, funding could vary from one year to the next, causing major difficulties and uncertainties for independent nursing home operators in terms of their business planning.

Furthermore, the legislation also states categorically that the minister may provide capital funding for a non-profit nursing home, entrenching in the new law the consultation paper's continued preference for a not-for-profit delivery system. Taxpaying private nursing home operators find it ironic that taxpayers' money should be used to develop public sector nursing homes while the private operators themselves face the prospect of increasing uncertainty.

Furthermore, this provision could enable the current Ontario government to effectively move in and take over private nursing homes along the lines of the current strategy of socializing child care operations. Uncertainty will lead to inaction and, if the government does not fill the breach, will result in fewer facilities when the need is for more. This is clearly a serious equity matter.

As a matter of policy, earlier Ontario governments decided that residential care for the elderly should be provided by both public sector and independent operations. Private sector business people have taken the risk. They've invested their capital and they've played a major role in fulfilling the crucial need of caring for the elderly. It is unconscionable that a business person should invest his savings in a business operation, fulfil a major need in the local community, provide an essential community service and then face the prospect of expropriation of a lifetime's work by the current government based on ideological grounds. This has already happened in the area of child care and appears to be the strategy with regard to independent nursing homes.

Now, who's next? The government's strategy of attacking the private sector service providers has already permeated many other areas within the health and related services sector, three of which I'm going to look at today.

In particular, the private home health care operators have real cause for concern at the present time.

These independent operators currently provide about 45% of the home health care services across the province and play a crucial role in enabling many of the elderly and the disabled to remain in their own homes. This is a vital service which can only grow in importance. Furthermore, these operators provide an efficient, innovative and flexible round-the-clock service for their clients, while their public sector

counterparts are more likely to confine themselves to a rigid 9-to-5 regime. If delivered by the public sector, the spectre in future may be that these facilities will close down on weekends, as many hospitals effectively are doing now. These independent operators, too, face growing uncertainty. Against the backdrop of the government's declared preference for a not-for-profit delivery system of long-term care, they are aware that they are currently the subject of government scrutiny and that a new system is on the drawing board which will virtually eliminate referrals to the private sector operators.

Another example is afforded by the case of the independent ambulance operators. All operators, independent and public sector alike, are rigidly governed by the Ambulance Act of Ontario and are subject to inspections, both prearranged and impromptu. All of this is as it should be. But the Swimmer report would change all of this. This report and the subsequent consultations held on its proposals led to widespread uncertainty and worry concerning their future among the independent ambulance operators who, like other private sector service providers, have invested heavily in their operation. To date, the provincial government has not acted on the radical proposals contained in this report, which was effectively a blueprint for converting the existing system of private and public operations to a public sector service. We strongly recommend that the government totally reject such proposals and focus instead on making the public/private sector mix of operations work better to get maximum value, efficiency and service for taxpayers' money. Similarly, the government should ignore the self-serving pressure by public sector unionists for these operations to be now reclassified as crown agents.

Meanwhile, independent operators are also experiencing unfair subsidized government competition in service areas which until recently have been exclusively met by the private sector. A particularly blatant example is to be found in the area of home respiratory services. This is an area which previous governments, as a matter of policy, decided not to get into and which has been fully served by private sector business people who have invested heavily to provide a vital service in the community. At the beginning of this year, a hospital in southern Ontario started to provide the subsidized service, with obvious advantages over existing private sector operators as far as referrals by medical staff are concerned. A senior official of the hospital concerned made no bones about the reason for embarking on this particular commercial venture, noting that the program was designed to capture a portion of existing markets in the community.

Finally, I come to our conclusions and our recommendations. The demand for health and related services, including nursing home facilities and home health care, can only escalate with the aging of the population. At the same time, however, the provincial deficit is ballooning and the province's taxpayers, both individual and corporate, are suffering from tax exhaustion. Under these very serious circumstances, it behooves government to ensure that the taxpayers' money is being used wisely. The government has a clear responsibility to provide the best possible care

for the recipients of social care services within tight spending constraints.

Just a week ago the Premier of the province expressed his deep concern over the debt problem facing the country and stated that change must be the order of the day.

1150

In the interest of containing public expenditure and obtaining the maximum value for taxpayers' money, we recommend that the Ontario government now change track and adhere to the following guiding principles:

- (1) Government must retain the private sector/public sector mix. In an era of growing pressures on taxpayers' money, sharply rising provincial deficits and a skyrocketing public debt, a skilled blending of private and public resources is required if we are to adequately address growing demands on the system.
- (2) Government must focus on making the existing system work better, creating an efficient, effective and economic service.
- (3) Government must ensure that the cost of the overhauled system is kept within the means of the taxpayers of the province, now and in the future.
- (4) Government must recognize that businesses need to be able to plan, and should act accordingly. For example, the uncertainty generated by the proposed service agreement for private nursing homes, as put forward in Bill 101, could well constitute a major obstacle to sound business planning.
- (5) Government must recognize that business owners have invested heavily in their operations. Therefore, if the government makes major changes to the rules which adversely affect private sector operators, it is paramount that these operators should have the choice of either staying in business or receiving fair and proper value for their business.
- (6) Government must separate the impulse to feed the interests of public sector unions from the need to provide a service to the public. To claim, as some unionists have attempted to do, that an independent operator providing such a service should be regarded as a crown agent is totally inappropriate and should be rejected outright.

The Chair: Thank you very much for your presentation. We'll move right to questions. Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. Although you mention you're a non-partisan organization, I appreciate you coming forward and pointing out some of the obvious flaws in the government's strategy, with this legislation in particular and in the direction of long-term care the government wants to take us in with the particular socialist twist it's got on it. I'll tell you, my caucus colleagues and I very often feel that we're the only ones out there screaming for the private sector, so it's encouraging, and has been encouraging, during this round of public hearings that many, many operators have come forward, and business associations.

I want to deal head-on with the word "profit". It seems to me that this government while in opposition was very effective at sort of changing the language of Ontarians, no longer talking about capitalism or free markets; in fact, labelling those as bad things, telling the public out there that "profit" is a dirty word, that if Mr and Mrs Smith own a nursing home, somehow they're evil, they've been ripping people off all their lives, that they made a profit. There's a fundamental lack of understanding by this government, its members and the unionists in that they don't understand business, that profit is redeveloped, that profit is generated back into capital.

I want you to take a couple of minutes and give us a little lesson about profit and where it goes, and maybe make the public out there—because we are on TV—a little more comfortable with the term.

Mrs Thompson: In this particular context, I think what we have to remember is that the private sector operators who provide the type of service we've been talking about today—child care, long-term care—are basically committed professionals who are doing a job which they have been trained for and which they have dedicated their lives to doing. The so-called profits they make, the so-called wages they receive, are, generally speaking, lower than what is received by their employees. They do not make much out of this.

Let's just backtrack a little bit. We have here a situation where people have put their life's savings into their business. They've invested, they're providing a service to the community, they are providing employment to local people. They themselves are not making much money at all. Very often their wages are lower than those of their employees.

What we're seeing at this present time is an increasing attack by the government on these people. We've seen it in the area of child care. I understand that today we're not looking specifically at child care, but this is the area that is right out front and centre. We have it in the area of the nursing homes.

If you take a look at this particular piece of legislation, you'll see that the service agreement is central. The service agreement, as it stands in this bill—which presumably is going to be amended—is an area which is going to cause a tremendous amount of uncertainty for these people. They have invested their money and they are now finding themselves in a situation where they're not able to plan; they're not able to plan their next little while.

Let's just take a look at the small business sector in general, the confidence level at the moment as far as small business is concerned. Small business confidence is very low at this moment in time. The government's attack on these businesses, these private services providers, is a large contributory factor. Just take a look at what's happened over this last couple of years since this particular government has been in office. We've seen a situation where company registrations have fallen by a quarter. We've seen a situation where, over the past two years, business bankruptcies are up by 70%. Why should anyone invest under these circumstances? Yet the government still expects the small firms to continue their record of job creation, for which the small business sector received recognition during the 1980s and is still effectively carrying out at this present time.

Mr Jim Wilson: Just to look overall at this government, it seems to me that it's playing a bit of a game here with the public in an attempt to salvage its ideology and to salvage many of the speeches it's given in the past.

I think of just two quick examples where the government seems to want to rely heavily on the private sector. One is the leaseback of the GO transit rolling stock: Essentially, US companies are going to buy rolling stock and will be able to depreciate that rolling stock on the backs of the US government in terms of tax breaks and depreciation, and the Ontario government will lease back the rolling stock over a period of years. It's one area where the Treasurer has already moved to have a reliance on the private sector, and you could argue that those US firms are, rather than what they used to call corporate welfare bums, now becoming government welfare bums. None the less, Floyd Laughren and company will benefit from them. The second one is the Treasurer floating around the idea of leasing back our computer systems. Again, the private sector will be asked to buy them, and we'll lease them back and get a benefit from that.

So on one hand there seems to be some recognitionin two areas anyway, and there are many other examples that this government has learned a few lessons in the last two and a half years. But then we look at this legislation and at the direction the government has been going in terms of health care and social services, with its continued preference for the not-for-profit sector. I wonder whether they really are just playing a game here, whether the idea of these committee hearings has been—because it really is boiling down to private sector bashing and the private sector having to defend itself, with the public sector and the unions coming here and bashing away at independent operators. That has become much of the focus of these hearings, rather than the content of the legislation that needs to be addressed. I wonder if that isn't part of the plan: Let's have CFIB pitted against the unions, and let's continue to do this ideology, the divide-and-conquer society, so they can go ahead and keep closing the hospital beds and they can go ahead and keep driving private operators out of day care and out of the nursing home sector. Because all the public sees is this fight between profit and not-for-profit, and it's a bit of a red herring. Do you have any comments on that overall picture?

1200

Mrs Thompson: I understand what you're saying. However, you have to also bear in mind that last week the Premier of the province indicated that change must be the order of the day. Now, as I indicated in my presentation, we applaud this.

Mr Jim Wilson: You didn't say what type of change.

Mr Jackson: Change the government.

Mrs Thompson: Drop the attack on the private sector.

Mr Jim Wilson: But at the same time he makes that speech, he goes to other countries and totally hammers the private sector and any trade agreements.

The Chair: Can you can answer the question? I'm afraid we're going to have to move on.

Mr Jim Wilson: It's part of the dual personality, I think.

The Chair: Mr Owens.

Mr Owens: Thank you, Chair. I want to thank you for your presentation. Needless to say, I have some difficulties with some of the assertions you've made in your presentation. Starting with page 3, when you talk about turning the facilities into rigid 9- to-5 regimes, you talk about hospitals that are effectively closing down on weekends. Can you let me know what hospitals are effectively closing down on weekends?

Mrs Thompson: Oh, I think this is an area that you yourself must do your own research in.

Mr Owens: Well, you've made an allegation here. I'd like to know which hospitals your group found were effectively closing down on weekends.

Mr Jackson: Joseph Brant Memorial Hospital-

Interjections.

The Chair: Order, please.

Mrs Thompson: You don't need to do your research; your colleagues have indicated.

Mr Owens: In terms of the preparation for your brief, are you familiar with the group called Concerned Friends?

Mrs Thompson: Why do you ask this, sir?

Mr Owens: I'm asking whether you're familiar with the group called Concerned Friends.

Mrs Thompson: There are a number of different organizations.

Mr Owens: Let me tell you about Concerned Friends. Concerned Friends is a group of seniors who act as advocates for seniors in the province. If you look at the back of the room, you'll find a person by the name of Freda Hannah, who is involved with this particular group. It might be instructive for you to go back and have a chat with Freda about some of the situations that are going on in nursing homes today. Further, if you had read the Globe and Mail's Focus section on the weekend, an article by Jock Ferguson and a sidebar article by Paul McKay talk about some of the things that are happening in for-profit nursing homes here today. I don't think it's a situation of pitting non-profit versus for-profit. This is real life. These are people who are not being treated appropriately. These are stories of these owners you talk about. Absolutely, there are people out there who are doing their jobs, working hard and doing the right things, but there are a lot of folks out there—again, you can sit down and talk with Freda Hannah about some of the things that are happening out there.

One of the private sector unions you take an indirect shot at made a presentation earlier this morning: the Canadian Union of Public Employees. These are figures that come from the Ministry of Health itself on form 7s that come into the ministry. Part 2 of their analysis from the ministry talks about resident care expenditures. I'd like you to tell me, when I'm finished this list and give you the differences in percentages, which you feel your organization feels could afford to take the hit in terms of the differential expenditures: continence care products, medical and nursing supplies, raw food costs, dietary supplies and services, housekeeping supplies and services and laundry and linen services. It goes on to say: "On an average per diem basis,

the non-profit homes spent 37.3% more than the for-profits on these resident care items in 1990. In 1991, the non-profit homes spent a full 42.2% more on these products and services."

In the view of your organization, which of these services—again, continence care products; medical and nursing supplies; raw food costs; dietary supplies and services; housekeeping supplies and services and laundry and linen supplies and services—in the view of your group, which of those should have taken the hit?

Mrs Thompson: I would point out to you, sir, that I am here representing the small business sector. I think that is the sort of question you should put to specialists in the field.

Mr Owens: With respect, you've come in here and taken a shot at the government. Your group has come in and started a new specialty in health care. I'm quite aware of what sector your group represents.

Mr Jim Wilson: Mr Chair, point of order.

The Chair: I think we'll just allow the witness to answer the question. That has to be her answer.

Mr Jim Wilson: On a point of order: Mr Owens, those statistics are out of order. Many of those non-profits don't pay property taxes or have the overhead the private sector has, yet the private sector has a smaller per diem. I suggest CUPE go back and incorporate all of the costs—

Mr Owens: On that point of order, Chair.

The Chair: Order, please.

Mr Jim Wilson: I can come up with a different list than Mr Owens.

The Chair: Order, please, Mr Wilson.

Mr Jim Wilson: I didn't get a chance this morning to pick on CUPE.

The Chair: Order, please. We are here to hear from the witness. A question has been asked. We have to allow her to answer that as she wishes. Do you have any further comment you wish to make on that last question?

Mrs Thompson: Thank you, Mr Chairman. I appreciate your intervention. I would like to return with some statistics of my own which in fact are not my own; they're the government's statistics. Let's get back to the central problem here. The central problem we're looking at is the increasing demand on the health care system. There is increasing demand on the system because the population is aging. Now I come to the statistics, and these are statistics I'd like you to think about.

The number of old people aged 65 years and over is going to increase over the coming 25 years from 1.1 million to 2.2 million. It's going to double, okay? That means that the proportion they make up of the total population is also going to increase. It is going to increase—and these are the government's own figures—from 11.5% of the total population up to 16.5% of the total population. The really old people, those who are aged 75 years and older, are also going to double in numbers, and their proportion is going to increase from 4.5% to 7.5%. There is a major problem looming before us with regard to the provision of care for the elderly.

Mr Owens: Absolutely.

Mrs Thompson: The recommendations I have made today, the guiding principles I have put forward today, are put forward in order to find some solution to the existing problem we all find ourselves in. It comes back to taking the services provided by the private sector—the independent operators—and the public sector and welding them together into an efficient system.

The Chair: Final question, Mrs Fawcett.

Mrs Joan M. Fawcett (Northumberland): Thank you for coming before us. Of course, this has been quite a battle as we have had these hearings: the private versus the public systems. Certainly I appreciate your comments on the independent ambulance owners too, because I've certainly had that problem brought up to me by the independent ambulance owners in my riding, who are really concerned that the government is systematically trying to devalue their businesses and then buy them out at a lower rate. That's another whole question as well.

If I could just carry on from what CUPE said this morning, there was one interesting statement where it said: "Permitting nursing homes to be run for profit under a lenient system of legislation and an impotent system of inspection is a measure of societal negligence we can no longer allow to continue. When an institution becomes the only answer for the care of an elderly person, it must be one that is run on a principle of loving care, not one of tender loving greed."

I wonder about that statement. First of all, the government talks about allowing everyone choices in life and yet it wants to certainly eliminate that whole system of choice. I wonder if you could just expand on your thoughts on that statement. Also, does one government-run deliverer of service, in your mind, ensure quality care? If we go to one system only, the government-run system, how can we be sure? I have been in both kinds in my riding, and we have good private care and good public care. I'd just like your comments.

Mrs Thompson: I would like to return to the guiding principles that I put forward. I think that we should retain the private sector/public sector mix and make it work better. We've got to have a more efficient system. Private firms are not averse to regulations. They welcome regulations. They want to provide a good service. This is the reason that they went into business in the first place.

They've invested their life's savings, very often, in order to set up their business and they are dedicated professionals. They're not making a lot of money out of this. In fact, many of them are taking less out of the business than their workers are receiving.

You should take the existing public sector/private sector mix and make it work better, but you've got a problem down the road inasmuch as the population is aging and the demands on this system are going to become very heavy. So you've got to ensure that the cost is kept within the means of the taxpayer.

I think that in reviewing the existing system of longterm care, the government must also realize that businesses need to plan and the government must act accordingly. It mustn't create this environment of uncertainty which many private operators are labouring under. We've got this situation in child care at the present time, and clearly there are difficulties in this legislation as far as the nursing homes are concerned.

I think also that the government must realize these private sector firms want to remain in business. They've set up their operations. This is what they have basically studied for. This is what all their expertise is moving towards. The business, for many of them, is basically their whole lives. I think the government has to recognize that too.

As far as the reference to greed is concerned, I would reject that completely.

The Chair: Thank you very much for coming before the committee.

We'll now stand adjourned until 2:15 sharp this afternoon when we'll reconvene. The committee stands adjourned.

The committee recessed at 1213.

AFTERNOON SITTING

The committee resumed at 1417.

ONTARIO COALITION OF SENIOR CITIZENS' ORGANIZATIONS

The Chair: Good afternoon, ladies and gentlemen, and welcome to this afternoon's session of the standing committee on social development. As I noted this morning, the organization that was to come at 2 o'clock was unable to do so, but the 2:30 group is here and, it being 2:15, we thought we might as well get started. So I would invite the representatives from the Ontario Coalition of Seniors Citizens' Organizations, if you would be good enough to come forward and take a chair, a glass of water, a couple of coffees, whatever, and make yourselves comfortable. If you would be good enough just to introduce yourselves for the committee members but even more importantly for the purposes of Hansard, then please proceed with your brief. We have received a copy of it. Welcome to the committee.

Mr Dan McNeil: Thank you very much. I'm Dan McNeil and I'm co-chair of the Ontario Coalition of Senior Citizens' Organizations.

Miss Mae Harman: I'm Mae Harman. I'm a member of the steering committee.

Mr Mark Frank: I'm Mark Frank, a member of the steering committee.

Ms Bea Levis: Bea Levis, co-chair of the Ontario Coalition of Senior Citizens' Organizations.

Miss Harman: Thank you for the opportunity to make a presentation on long-term care. The Ontario Coalition of Senior Citizens' Organizations, which I will refer to as OCSCO from here on, is an umbrella organization of seniors' organizations in Ontario. It came into being at the time when the federal government was attempting to deindex old age security. Its interests have broadened since that time to include a variety of seniors' concerns, including long-term care, auto insurance, taxation, universality and many others. Membership in OCSCO presently includes 46 different groups which have a total membership of approximately 300,000.

OCSCO was one of three organizations comprising the Senior Citizens' Consumer Alliance for Long-Term Care Reform, which held 16 days of hearings and two forums involving the principal stakeholders in long-term care. Mark Frank is going to present our major paper.

Mr Frank: Before I deal with the actual text that you have in front of you, I want to explain that I may be departing from the text in the interests of time, and since you said we were early, I assume we have 15 more extra minutes on our time. However, you'll bear with us.

The Chair: The Chair is always open-minded on these matters.

Mr Frank: Before I get into the substance of this brief brief, we and I cannot let this moment go by without commenting on this important and auspicious day, March 8, which is the day of our appearance. It marks the Canadian and worldwide celebration of the achievements of

women throughout the decades, their struggles for equity and against their senseless victimization. It also marks their renewed dedication, along with their allies', to better respond to the challenges and issues that still confront them.

I want to draw your attention to the button I'm wearing. You cannot see the wording from where you are, but it is the symbol of International Women's Day, 1993. The words on it are "No Time to Stop." Not a bad idea for any committee that is engaged in this important task of reforming the long-term care situation in our province.

Among the issues that bother women in our province is certainly the delivery of health and long-term care, because from the home through the community to the facility and into the institution, women make up the overwhelming proportion of the workforce, often at inadequate or unequal pay rates or without remuneration of any kind. We know that 90% of all the long-term care delivered across Ontario takes place in the home, and mostly by women who receive little or no funding and face difficult conditions as primary care givers. We will deal with that problem to some extent in our presentation, but we thought it important to remind ourselves that this was this day, specially marked internationally and in Canada, and this area we're dealing with does for the most part preoccupy working women.

The Ontario Coalition of Senior Citizens' Organizations, OCSCO, greets the tabling of the legislation dealing with the long-awaited need for an integrated and quality delivery of long-term care. We do not delude ourselves into thinking that Bill 101 copes with the extended meaning of a long-term care system, which must include, for example, youngsters requiring such care and others, or that it meets all of our concerns, nor do we believe the current Bill 101 and its declared aims can be meaningfully addressed separated from and out of context with the need for an ongoing overall reform of health services in general.

There are two vital questions, I think, in front of us: Will the Bill 101 changes accord with the as-yet-unannounced policy framework on long-term care and the expected chronic care role study report, and will the above as-yet-unreported announcements reflect the concerns of seniors and others seeking a genuine long-term care reform?

Some general observations: Seniors, as users of longterm care facilities, deeply appreciate the special support from ministries directly involved in long-term care reform. The resulting set of public hearings organized by the Senior Citizens' Consumer Alliance was an innovative form of user empowerment which needs strengthening in the period ahead in all directions.

We believe it is necessary and vital to a meaningful reform and its implementation that users be directly involved in governing and driving the proposed new system. Any effort to enlist seniors or users as advisers in the now obsolete, stereotyped sense is unacceptable. Basic commitments of the government itself to deliver overall health services will have to be adhered to and the autonomy and independence of users whose partnership is sought in implementation must be thoroughly respected when they offer critical input.

A major concern is that a long-term care reform not be undermined by the present economic restraint programs and priorities outlined by Minister of Finance Laughren. This wide swath of cuts in health service dollars for the critical years ahead seems to be a policy which the present superministry, corporate-model cabinet threatens to continue.

Our parallel concern, of course, is that Queen's Park will not strongly enough challenge similar belt-tightening moves by Ottawa to weaken our health services. We seriously doubt we can proceed with massive dollar cuts and layoffs in health services while advancing a reform in long-term care.

Does Bill 101 actually lead us to the promised land of meaningful long-term care reform? Or is this again a case of government lawyers and providers fighting it out while the consumers are outside looking in? We need to know more precisely how this legislation begins to address the concerns and recommendations set out in our widely supported Advance Report (1992) of the seniors' consumer alliance. It is reported that the final policy paper outlining a framework will not be released until late March, obviously too late for our response to be made here. In the absence of a framework, we question how the details of Bill 101 relate to the broader picture.

It's unfortunate that the policy on chronic care facilities and chronic care in general did not appear as an integral part of the long-term care reform consultation. This was inevitable once the chronic care study was separated out. We need some reassurances that whatever positive policies come forward be appropriate and not destructive. They must be reintegrated as part of the continuum of long-term care.

The idea being aired that nursing homes and homes for the aged be funded and reformed into kind of hospitals able to provide medical care—oxygen, suction, IV and heavy nursing care—is dangerous to the future of older residents in Ontario. Our question is, are heavy patients going to be switched from chronic care and acute care hospitals into nursing homes and homes for the aged under Bill 101?

The lack of a policy framework puts us in the position of being asked to take Bill 101 on faith and trust. We do not think this is the best way to go about things. New funding options, for example, should not mean increased user fees—copayment—in nursing homes and old age homes in the name of a consistent resident payment policy. Fairer funding should not mean even-handedness between the not-for-profit and the for-profit sector.

What does this bill do in fact to promote non-profit care? Since this matter of profit and non-profit care has been with us for a while and has agitated these hearings, I believe, I would like to recommend two recent books to the members of the committee: a United States book, Marketplace Medicine: The Rise of the For-Profit Hospital Chains by David Lindorff, Bantam, 1992; and in Canada, The New Bureaucracy: Waste and Folly in the Private Sector, by Herschel Hardin, McClelland and Stewart, 1991. I think both these books are very instructive on the subject and are worth reading.

The decision to impose increased user fees for nursing homes is a bad one. It will not help those it claims to help.

It will hurt those least able to pay. While the rationalization of payment appears seductive, it punishes the most vulnerable. How the increased revenues will be disposed of is a matter of concern if it advantages for-profit nursing homes.

1430

In the matter of moving funds to the community, the power to redirect funds from expensive, over-endowed pools of institutional money does not in and of itself guarantee success. It could in fact create turmoil and costs of another kind; for example, the consequences of unplanned layoffs of hospital staffs.

The power to flow funding could find funds going into the wrong administrative structure empowered to dispense such funds; for example, to the service coordination centre model widely rejected in the public consultation. I believe there are some recommendations that there be changes along the lines we have suggested here in our brief and elsewhere

New roles being suggested for the district health council system and the proposed comprehensive multiple service organization are dramatic proposals, but they are not instant fixes. They require a dedicated overhaul of the current system in order to realize their roles, mastering a new mandate and enhancement, on the one hand; on the other, an awakened and new kind of input by users and their empowerment.

The need to strengthen the right to appeal, particularly affecting placement facilities or assessment, is a paramount concern. Such rights to appeal should be kept simple, direct, without delays, bureaucratic levels or complex litigation.

During our public hearings, we heard how a shift to the community would have a major impact on already overburdened family care givers, most of whom are women who receive virtually no compensation for their labour. The legislation lacks a response to this growing calamity. In addition, the presumption that family support is available is often made when there are no family care givers. We should not be cutting back on institutional care until appropriate community services are available.

During the consultation, there was widely expressed fear that the shift to community-based care would not be accompanied by a well-planned expansion of community and in-home services. The new influx of users as well as the new demands and complexities of in-home care require skilled, trained and decently paid workers.

The economic and administrative cutback in institutions and hospitals has resulted in mass layoffs of workers. This occurred without proper consultation with union representatives of the workforces affected. Appropriate relocation and retraining is essential. Anything less makes a mockery of community planning programs.

Success of long-term care reform rests on the issues of governance, accountability and empowerment of users. Will there be meaningful involvement of users? Much has been said about the empowerment of users and seniors, but there is little of substance to support all the talk. At most, the lowest common denominator approach has been used in its implementation.

I had an opportunity to catch some sessions with Deputy Minister of Health Decter before the standing committee on public accounts on February 24. I urge you to look

at that Hansard. It gave me, personally, bad vibrations. Why? First, the emphasis on the high expectations of seniors and users of long-term care putting, in effect, almost a guilt trip on seniors, disabled and others affected.

The answer to meeting the high expectations was to issue a lot of fact sheets. Well, there's either feast or famine. It's either information overload or information zero. May I suggest that sometimes information overload is the equivalent of information zero because it doesn't get through anywhere. But the really loony suggestion that aired in those public accounts hearings had to do with the question of issuing an annual statement of services. Even Mr Decter had to report that this was kind of intimidating. If every user is going to receive an annual statement of services, not a bill, a guilt trip is being put on all the users of health services in general, and particularly on the vulnerable and the long-term care recipients. The professionals in the field were very worried about this particular idea of informing people. It's a bad idea.

Second, a rationing of medical procedures: Is that in the wind? Is there an Oregon plan coming for Ontario? We're told that the government is now spending \$4 million a year to have nine doctors study all the procedures. Mr Decter tells us that according to the Rand Corp, which I think is a US-based corporation, 30% of all procedures are useless, so therefore there's reason to examine this. We're told that nine specialists are looking at this problem at Sunnybrook. The question arises, since I've raised the question of empowerment, are the paramedics, the thousands of workers organized in CUPE or in OPSEU, part of this consultation? How effectively are they part of it as to what fat should be cut in the procedures area? I think not. Last of all, of course, the users are not being consulted, or if they are consulted, it's at a distance.

The other preoccupation of the public accounts hearings was the health care fraud. There is misuse of the health card but the big fraud is elsewhere, in our opinion. That needs primary attention. The big fraud, for example, is the pharmaceutical companies. If Mr Clinton and Hillary could find that out, why can't we find that out here and deal with it, rather than focusing on that as the major issue to spend most of the report on?

Finally, Mr Decter is calling for exporting of our expertise. Is that to dovetail with the new NAFTA agreement? We wonder. Are we going to sell our medical expertise to the highest bidder somewhere? That's not so wild an idea. It's happening. There was a story the other day that Mead Johnson Canada, but really the United States, has made a deal with a women's hospital for taking over the infant formula.

You as a committee should have a look at that, because if that's what we mean by exporting our expertise, we're ignoring northern Ontario, the suicides at Big Trout Lake—incidentally, Big Trout Lake elders are part of our coalition. We're ignoring the suicides at Osnaburgh and so on. Let's do a little bit of export of our surplus doctors and our surplus expertise into the rural areas of Ontario and the aboriginal areas and hunting areas of Ontario.

1440

I am being told that I should generally cut down, and so I will swiftly move to the windup paragraph in my part

of the submission, which is to say that any appeal by government—I want to stress this—or other players for a partnership with users must ensure that the latter not suffer a loss of autonomy and independence in the process, either as individuals or as those trusted and tested organized sectors devoted to user advocacy. I'd like to consider our organization one of those. There should be no mistake about who is a consumer; they are the final users of the facility and service.

Now I surrender to Mae.

Miss Harman: I'm sorry that you have before you a handwritten summary.

In summary, the prime concern of OSCSO is that to date we have little information on a comprehensive, integrated plan for long-term care in Ontario. In spite of all the consultations, written presentations, hearings and forums, we have few answers as to how long-term care will proceed. We worry that this may be a repeat of the mental health fiasco of several years ago, when institutions were downsized and people returned to their communities without community care in place. Ernie Lightman's recent report on boarding homes is one more piece of evidence as to how society has failed those people.

To date we have, through Bill 101 and other announcements, a piecemeal approach of new funding arrangements for institutional

care, a homemaking program, a placement coordination system and some assistance to palliative care. All of these are being set up, presumably, without input from planning bodies or consumers at the local level. To whom are these programs responsible? Will they be funded out of the community envelope? How will they dovetail with a comprehensive program of continuity of care ranging from health promotion to chronic care?

OCSCO looks for assurance that the following needs are met in a comprehensive long-term care program:

- (1) Social needs as well as medical needs must be met; counselling, housing, transportation, socialization, shopping, assistance with those chores that homemakers cannot manage. Social workers must be a part of both assessment and care provider teams.
- (2) District health councils as well as local long-term care committees must be transformed to include representation from social services, social planning bodies and consumers.
- (3) Local planning bodies must have some overall authority for funding and programming as well as for planning.
- (4) The area coordinators, who were so criticized as another and unnecessary layer of bureaucracy, must be removed from the picture.
- (5) In areas where some comparable body does not already exist, comprehensive multiservice organizations must coordinate and carry out long-term care.
- (6) Ethnocultural programs which provide long-term services to special groups whose language and culture differ from the larger community must be recognized as special units of comprehensive care.
 - (7) The needs of native groups must be addressed.

- (8) The special burdens of family care givers must be recognized, and such care givers must be supported with financial assistance, counselling and respite care.
- (9) Consumers must be truly involved as partners at all levels of policymaking and programming. Being informed is not sufficient involvement.
- (10) There must be simple and clearly stated mechanisms for complaints and appeals regarding admission to services and inappropriate and inadequate services.
- (11) The relationship of the Advocacy Act to any legislation re long-term care must be clarified.
- (12) The special contribution of freestanding chronic care hospitals must be recognized, especially in regard to persons with need for intensive care and for the role these hospitals play in research and training in gerontology.
- (13) Rehabilitation programs must be restored and used to help consumers regain health and independence.
- (14) The role of volunteers must be recognized and supported.
- (15) The not-for-profit principle in long-term care must be protected.
- (16) User fees are counterproductive. They discriminate against those who can't afford to pay. Means tests are demeaning.

As seniors, we want to maintain our independence and dignity. We want the right care at the right time and in the right place. We have worked hard all of our lives and contributed to our communities and we still do, and we paid taxes and we still do. We feel we deserve a fair deal.

The Chair: Thank you very much for your presentation and also for a bit of a summary of public accounts from last week. There have been a number of issues in the health care system that have been discussed, not only in this committee but elsewhere as well. We'll move right to questions. Ms Carter.

Ms Carter: Thank you for your well-informed and caring brief. I think we're all aware that we have a disadvantage in discussing this bill in that it is just part of a pattern, so that there's a lot more to come and there are a lot of questions that are just not answered yet. But I believe the policy framework document is out there now. I haven't seen it yet, but hopefully we'll all have access to that very soon, and I hope that will fill in some of the gaps.

Certainly the principle of consumer choice is very much in the minds of everybody who is involved with this legislation, I do know that, that we respect the need for maybe an ethnic institution or whatever the special need might be.

What I really wanted to ask you about was the question of user fees. You seem to be very unhappy about what is being suggested in Bill 101, but I would have thought that what we have there was quite fair. There is a lot of discrepancy now: Some people are paying far more and others are paying far less just because of where they happen to be and for no particular reason.

Of course, under the bill the fees will be for accommodation only, so that as people get to need more care this will not affect them financially or the services that are provided for spiritual care, occupation, entertainment, all

those things, will also be funded by the government so that they won't accrue to the person, except maybe a cable TV charge or something like that.

The remaining fee will be much more consistent right across the board. I believe it's going to be something in the order of \$38. Of course, only income will be taken into account, not assets, so that it will just be a very quick process. My impression so far has been that a lot of people feel that is good. It will bring a little more money into the system. On the other hand, a lot of people will pay less than they have been paying up to now and, of course, if anybody can't afford those fees they will nevertheless not be penalized, they will still receive the accommodation and the services.

I just wondered if you could say a little more about how you would like that changed so that you would find it more satisfactory.

Mr Frank: I did too much talking, so I want to yield the floor to somebody else to deal with that.

Mr McNeil: As a coalition, we're not happy with the user fee in any form, and we certainly realize that when you use words such as "copayment", it's only simply to dress up two of the words we dislike the most. We are not in agreement. We realize that you made an adjustment there, and I'm trying to remember what the old system was—\$50 against \$30 or something.

Ms Carter: Some people were paying in the \$20s and others as much as \$90.

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Mr McNeil: All this system is doing is putting us somewhere in the middle. Our coalition believes it is putting a harsher payment, or whatever you want, on those people who can least afford it. We are not happy with the words "user fees" or "copayment." We don't think they should be used at all.

Ms Carter: Although by definition everybody is going to have enough money because of the income supplements that seniors automatically receive.

Mr McNeil: I don't agree with that. I gather that you people have a different opinion of that, but I don't see that anything that's happening now, in any form of payment to people,

in whatever way that is, is going to help us with a user fee, copayment fee or anything else. That's just my opinion. Anybody else here?

Miss Harman: Not around Bill 101 but in terms of care in the community, in the home, there was some talk in the beginning that certain medical care would be provided without fees but that for any kind of social care there would be some kind of copayment or user fee. I don't know what the picture is on that now.

Mrs Sullivan: I want to tell you how impressed I have been in the past with the work of OCSCO and the work you did in association with the alliance for long-term care. It was very valuable, I think, to all of us.

I'm interested in a number of things you've raised today. I'm going to concentrate only on the one, the financial aspect of your presentation, although I must say that I

think your words of wisdom with respect to chronic care, by example, and several other areas are very valuable.

Your second recommendation relates to increased user fees as being counterproductive. One of the things that has occurred to me as I've been looking at Bill 101 is that in the three areas where it calls for payments from the government to the nursing home, the charitable home or the municipal home for the aged, the legislation says that the funding will be provided to assist in defraying the maintenance and operating costs incurred or to be incurred by the home, municipality or charity.

There is no ceiling and the difficulty is that the act isn't any more specific than that funding will assist. It doesn't say that it will cover all the costs of nursing care or other care, by example, food. It doesn't say that all those costs will be covered. We have to take it on good faith that only the accommodation portion will be charged to the resident, that no other costs, perhaps next year or the year after, in relation to nursing or other needs may well be added on to the copayment. I wonder if you've discussed that issue with the ministry officials in association with this particular piece of legislation and how you see that washing out.

Miss Harman: One of the things I wondered is, is this a place, an area, where the institution will cut corners and save, since the money may not be forthcoming for it—perhaps not nursing care but, for example, recreational programs and that sort of thing—whether they'll get short shrift.

Mrs Sullivan: I think that's a fair concern. One of the things we know is that the homes have agreed and ministry requirements will be that nursing and food costs are passed on. Even if it's the commercial sector, there will be no profit made in those sections.

The difficulty is that the care plan, by example, should be a multidisciplinary care plan. It should include more than simply nursing care and food; it should include recreational services and so on. What if the money that the government flows to assist in defraying those costs simply doesn't meet the requirement even of the care plan?

Miss Harman: I think that's something that has been a matter of concern to us.

Mrs Sullivan: If you are in further discussions with the ministry and want to consider that particular section of the bill, I think that members of the committee would be very interested in further discussion that you might want to bring back to us by letter or whatever. I think it's a real problem.

Miss Harman: Thank you. That's a good idea.

Mr Jackson: I'd like to commend you for your presentation. I appreciate hearing from your organization and the insights you bring. You have covered a lot of area, so I'll try to focus in two areas. You are aware, of course, that in spite of the government saying this process has been widely consulted prior to getting here, what we really didn't consult or talk about over the last two and a half years was that we are moving from an insured service to a contractual service with the state, that in fact the Ontario government is delisting extended care as an insured benefit, that the Ontario NDP government is bypassing the constitutional guarantee under the Canada Health Act and that we're moving into a contract agreement between the state

and those persons it deems approved and appropriate for health care. Are you fully aware that the implications of this legislation are as clear and concise and meaningful as what I've just said? Are you aware of that?

Mr Frank: We keep learning things all the time about this legislation, and your revelation is no surprise in that sense generally. But my sense is that a lot of the things that are going to be imposed on us are going to take the form of regulations. We have not seen those regulations, and regulations change. They have a habit of changing with governments, and I include all governments.

Incidentally, the leader of the former Liberal government called user fees, when they were advanced for the hospital service, a "sick tax." Right on. But we're still hearing that idea, that user fees are the panacea to our financial problems; we think otherwise. We think there are other places to get that money and that we shouldn't undermine universality in trying to settle budgetary and fiscal matters.

Mr Jackson: But you'll forgive me, the two issues are separate. User fees are separate from the issue that this is currently an insured service in Ontario, protected and covered by constitutional guarantees—

Miss Harman: And a right.

Mr Jackson: —and a right, and they're guaranteed and protected under the Canada Health Act. But this legislation opts us out of that framework and puts us into a contractual service agreement.

Are you aware and have you communicated this revelation to your members, that this is a fundamental leap in the approach here? The uncertainty of where it takes us is just that, the uncertainty, but what is clear in the legislation and the statements by the parliamentary assistant and the minister in the House are that this is no longer a guaranteed insured service under OHIP, as protected; it is now moving out of that.

Though they say they would never do that unless there was proper public consultation, we believe, and we've heard from groups, that this point was not publicly discussed and debated during the consultation period. I was more or less looking to you, as people who have been closely associated with some of the discussions with the government, to know if this point was ever glossed over or ever dealt with up front in its full impact, or was always sort of implicit in the wings but is now happening in the legislation.

I think this is the fundamental issue here of the change that is occurring. All the rest is fine-tuning, bells and whistles, who pays what, who gets access, who is the gatekeeper, who will lose, who will win. But the fundamental change here is that it's no longer a guaranteed service, an insured service, and we're moving to a contract service. I wanted to focus on that, because I want to make sure that your awareness is at the same level as ours as legislators, who have asked these questions of legal counsel and others.

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Mr Frank: Can you cite that legislation?

The Chair: I'm afraid we are going to have to finish up, but please complete your response.

Mr Frank: I just wanted you to cite that section of the legislation.

Mr Jackson: It's the section dealing with the Health Insurance Act amendments

Mrs Sullivan: I wonder, Mr Chairman, if we could have a clarification from the ministry at some point on that point

Mr Jackson: We can get the pieces of Hansard, because it's been raised several times.

The Chair: Okay. We will do that.

I regret that the Chair always has to play the heavy. We've reached 3 o'clock and I must call this part of our afternoon to a close, but I want to thank you all for coming down and joining us today.

Miss Harman: You've given us some homework, which we will deal with.

The Chair: Mr Wilson?

Mr Jim Wilson: Just a question to research. When will the next summary of recommendations be made available?

Ms Alison Drummond: It's being worked on in the office. I don't know if other people are experiencing this, but we have a lot of illness among the support staff. We're hoping to get it to you tomorrow.

Mr Jim Wilson: Thank you.

BENDALE ACRES HOME FOR THE AGED, HOME ADVISORY COMMITTEE

The Chair: I call on our next presenters, the representatives from the home advisory committee of Bendale Acres Home for the Aged. Would you be good enough to come forward? Welcome to the committee this afternoon. Please be good enough to introduce yourselves, then go ahead with your presentation.

Ms Valerie Clarke: Valerie Clarke, chairperson of the home advisory committee of Bendale Acres Home for the Aged.

Mr Gord Blades: Gord Blades, committee chairman of the Bendale Acres home advisory committee.

Ms Clarke: Thank you for giving us time. Bendale Acres Home for the Aged was established in 1963 by the municipal corporation of Metropolitan Toronto to provide care for 300 residents aged 60 or older. At present, Bendale is under major renovations to provide private and semi-private rooms with ensuite washrooms.

Bendale Acres also provides community services which include adult day care, a geriatric day program with Scarborough General Hospital and Meals on Wheels. It also supports a satellite home program for residential care for 130 persons at Cedarbrook Lodge and Livingston Lodge.

The 13-member home advisory committee of Bendale Acres is made up of residents, family members of residents, representatives of local service clubs, professionals and concerned citizens. Our mandate is to act in an advisory capacity regarding issues related to the care of residents and the needs of seniors in the community and to act

as systemic advocates making recommendations related to the rights and common good of residents.

We endorse the principles the government has espoused in its long-term care redirection, but have some concerns regarding Bill 101 and the following issues: consumer choice and funding.

Consumer choice: Part of the reform initiatives was to recognize the right of the people of Ontario to choice and improved quality of life. With Bill 101, there is a lack of choice. The following reduces the control individuals will have over making decisions that affect their own lives: the decision of where to live; residence in a home that meets their ethnic, religious and language needs; the spouse to remain with an eligible partner even when not meeting the criteria. We are concerned that only the placement coordinator will make the decision, without any input from the consumer or the facility as to meeting their ethnic, religious, language or other requirements.

As we all age, we still wish to retain the ability to determine our future and to have our needs looked after by a province that we have supported with our tax dollars. To have no choice in where we are placed and little or no chance of transfer to our choice after admittance does not bode well for the quality of life for us as we grow old and need care.

Funding: Residents and families of residents have not been advised that there will be additional charges for their accommodation due to Bill 101. When does the government intend to advise consumers that they will have to pay more and that extended care benefits will no longer apply?

Also, Bill 101 is revising residents' copayment scheme to be based on an income test only, rather than the current formula of income and assets. Individuals who are income poor but asset rich will be supported by the taxpayers. This places a greater financial burden on an already diminishing taxpayer base. The assets will no doubt be passed on to the families instead of paying for the consumer's care.

Many of our seniors do not have pension plans other than the old age pension, especially women. Widows may get a portion of their spouses' pension, but the vast majority would be income poor. However, their nest-eggs, if any, would be in assets. If you look to having some kind of tax levied at death to offset the expenditure undertaken by the province during their stay in a facility, then this could be years in coming, as people are living longer, but the province's outlay is immediate. We would urge that the formula of income and assets test be kept.

What happens when there is no longer a Canada pension plan available?

When we talk of funding for accommodation being paid for by the resident, and health care needs by the province, where is there funding for the stimulation programs that are a necessity for the continuation of quality of life for the elderly? If these types of programs are not maintained, we will see our elderly shunted off to the side and left to vegetate. Also, where is respite care when a care giver is unable to provide it due to illness or extenuating circumstances?

In conclusion, a major concern is that in some areas there are very broad statements. What guarantees do we have that we will have any input into the specifics which, when decided, could run contrary to the overall principles the government has espoused?

We thank you for the time to present and we hope that you and your committee will consider the points we have brought forward when making your recommended amendments to the Legislature.

The Chair: Thank you for coming and making your presentation. We'll start the questioning with Ms Fawcett.

Mrs Fawcett: Thank you for coming before us. We've had many similar types of presentations and many of the same kinds of concerns brought before us because, as we are finding out, people don't find in the bill exactly what gives them assurance.

Consumer choice is one area where we've heard a lot of concern. People are afraid they're not going to have a choice of where they want to spend the rest of their lives, especially in the ethnic area. That's a definite area that should be spelled out. We will be making amendments and putting forward amendments to the bill. Had you thought of anything you might like to see included in the bill around the placement coordinator? Another question is, do you have a placement coordination system now that you operate under? If not, how would you like to see the bill changed?

Ms Clarke: We don't do the placements. Bendale is under Metro homes, and the placements are done by Metro homes

Mrs Fawcett: And it works well?

Ms Clarke: Yes, it does. I think it's more from the point of view that with ethnic people, they need to feel there are people around they can communicate with, especially at times when physically they're not as fit or they need a little extra care; someone with the same language, the same background. It's very necessary for the quality of life.

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Mrs Fawcett: Do you have access to respite care at all?

Ms Clarke: There is some; it still is there at the moment. But my concern is, when Bill 101 comes in, what's going to happen? If a mother has children, and she's looking after her parents or in-laws, what is she going to do if there are circumstances beyond her control or when she needs a vacation? What's going to happen? Are you going to have people coming in and out of a home to give them the care, or are you going to have a facility where someone can go for two weeks to get some help?

Mrs Fawcett: We have been given some assurances from the ministry that if there is a placement coordination system in place, it will either be built upon or used. Certainly we're hoping to see that that is definitely what happens.

Mr Jim Wilson: Thank you very much for your presentation. I am particularly interested in your comments with regard to the income test. I gather that it's your experience that seniors don't object to the fact that currently, in municipal and charitable homes for the aged, there is an income and asset test. You've not had any problem with that?

Mr Blades: Not that we are aware of.

Mr Jim Wilson: Do you have any personal thoughts on why the government is going to strictly an income test? I find it completely ironic that a social democratic government is going strictly to an income test tied to the guaranteed income supplement, given that in my area of the province it's not uncommon in terms of farming to have large assets, for instance, but zero income.

Mr Blades: It's easy to hide some of the assets of the people, by way of their children, and not show the true assets of the individual.

Mr Jim Wilson: Just to give you credit, in terms of funding you also say that extended care benefits will no longer apply. From my reading of the bill and from what groups tell me, it seems to be the first delisting of an insured service. As Health critic, I asked the minister in the House a couple of times last year, and she assured me that she wouldn't delist any OHIP services until there was a full and frank public debate about such a delisting. The previous presenters from the seniors' coalition touched on the fact that maybe we're going towards an Oregon system of care or something. Has there been much discussion in your community about the loss of extended care benefits and the new service agreement model we're going towards?

Ms Clarke: I don't think many people know about it, outside of people who are very involved with the issue. I think that's part of it. Even talking to people in my daily conversations, they don't know what's going on. Some of them, when you talk to them about extended care, don't even know they have that right.

Mr Jim Wilson: It's been a constant approach of this government that it uses these committee hearings as the public vetting of a piece of legislation, rather than taking the draft legislation out to the communities and getting it straightened out before it comes to committee, so I certainly appreciate your taking time. We will do what we can to introduce amendments along the lines you've suggested.

Mr Owens: I want to thank you for coming today and representing the riding that starts on the other side of Lawrence Avenue from where your particular home is located. I have some familiarity with Bendale. In terms of some of the issues you raise with respect to the spouse remaining with an eligible partner, what kinds of things does Bendale currently do now to ensure that happens, and how would it be impacted with the advent of Bill 101?

Ms Clarke: Just looking at Bill 101 and its very strict criteria, I feel that at present the criteria for coming into a home are not as strict as they're going to be with Bill 101, because there is some ability of people who need care. When you've got spouses who go into homes, I've watched where the other spouse has almost automatically needed to go into the home within a very short period of time. It seems they often need that ability to be with the spouse on a lot longer term than just coming in on a daily basis. Their health and their quality of life deteriorates.

Mr Owens: In terms of the ability for residents to transfer, say, within Scarborough, if somebody was devolved from Scarborough General, for instance, into Bendale but decided he wanted to move out to Seven Oaks because it's closer to home, how easy is it for you to arrange that kind of transfer at this point?

Ms Clarke: The home advisory committee doesn't do transfers;, that's done by the social and the home. It's not as easy but it is done. We've seen people come, not so much Seven Oaks because Seven Oaks is—

Mr Owens: Another Metro home.

Ms Clarke: —is under Metro homes but it's also in the facility; it has a longer waiting list. Bendale has a short waiting list at the moment because it's under renovation. Some of the homes do have short and long waiting lists, but they have the ability to transfer at the present time. My concern is that in the criteria you give there are three categories and then there's a fourth: transfer to other homes. That concerns me because just even reading that, there's a concern that the choice is taken away because you're saying that at the very end there's a transfer to other homes.

Mr Owens: I appreciate your concerns around respite as well, and I know committee members on this side of the committee share that. For that reason, there are provisions within the legislation for respite care that currently, I would suggest, probably happen on an ad hoc basis. You're quite right that care givers, because this isn't just a piece of legislation addressed particularly to seniors but also persons with disabilities, and others tell us there's a critical need for that kind of respite care across the province.

Ms Clarke: My concern on that one is the fact that the care giver at home is going to be away and they're going to have people coming in and out of that home because of the way the bill talks about the social services doing more care giving in the home, and that there will not be an ability, because of criteria, for them to get into a home at least for two weeks to get good care.

Mr Owens: My understanding, and perhaps the parliamentary assistant could clarify for me, is that there will be institutional beds provided for that purpose.

The Chair: If we could move, there were a couple of clarifications the parliamentary assistant wanted to make, so we'll deal with that and the other points.

Mr Paul Wessenger (Simcoe Centre): Thank you very much for your presentation. One of the points I will have clarified is the whole question of respite care, but first of all, I'd like to assure you that it's certainly the intention of this legislation that there be consumer choice in the matter. Perhaps it's the way the legislation is drafted. It's very difficult sometimes to encompass intention in legislation, but I can assure you we're looking to see if there's a way to ensure that intention is set out in the legislation because it's clearly a basis that there should be consumer choice.

Secondly, with respect to your comments concerning quality of life, as part of the funding program there will be specific money set aside for quality-of-life programming, and that will be in the funding formula and they'll be reimbursed dollar for dollar. That certainly is being addressed.

With respect to the respite care situation, certainly again it's policy that respite care be available both at the community level and also at the institutional level, and we certainly believe there's been an enhancement at the institutional level. If I might have permission, I'll ask staff to indicate how that is going to work.

Mr Geoff Quirt: I am Geoff Quirt, acting executive director of the long-term care division. Currently, with our health insurance approach to funding extended care, we can only pay for services that are delivered to one of our insured clients. The new contractual arrangement with facilities will, in effect, fund the facility to keep beds open for respite care purposes. If a particular facility has a high demand for respite care, then our expectation of its occupancy level will be reduced to allow it to keep more beds open to meet the respite care needs in its community while still providing 100% of the funding committed to in the service agreement.

The Chair: Any thoughts or comments on those comments?

Ms Clarke: No.

The Chair: Fine. Thank you very much for coming here this afternoon and for making your presentation. Good luck with the renovations.

FAMILIES' ASSOCIATION OF OAKLANDS REGIONAL CENTRE

The Chair: I call on our next presenter, the Families' Association of Oaklands Regional Centre. If you would be good enough to come forward, please make yourselves comfortable. Welcome to the committee. We've received a copy of your presentation. If you would just be good enough to introduce yourselves, then please go ahead.

Mrs Catherine Rhodes: I'm Catherine Rhodes and this is Kit Nero.

The Chair: Welcome. The microphone will pick you up just fine if you sit normally. You don't need to lean right up to it.

Mrs Rhodes: Is yours on, Kit?

Mrs Kit Nero: Is this on?

The Chair: It will come on when you're speaking. We have these magic people up on the side here who do all sorts of wondrous things to make sure we're heard.

Mrs Rhodes: That's good.

The Chair: Please go ahead.

Mrs Rhodes: I'll begin by telling you that we are grateful for this opportunity to bring our presentation to the standing committee on social development. This has to do with long-term care and services. Our group is concerned with equity of access for developmentally disabled people in Ontario, equity of access to the range of services provided for the physically disabled people and elderly people.

Who are we anyway? The Families' Association of Oaklands Regional Centre is a group of 127 persons organized to act in support of Oaklands Regional Centre and

its residents. Each member is a relative or a legal guardian of an Oaklands' resident.

Within the broad population of persons with developmental handicaps in Ontario there is a minority group of individuals. For this minority group, it is either the severity of their level of retardation or the complexity and chronicity of their additional physical or psychiatric handicaps which, when combined with their intellectual impairment, add up to a severe lifelong disability.

This group of adults with special developmental disabilities who require long-term care and special advocacy need the protection of the full range of the provisions of Bill 101. Most of the current 104 residents of Oaklands Regional Centre are representative of this minority of persons with complex, high-care-needs developmental disabilities.

The issues we want to go over with you: First, most of the individuals with developmental disabilities we represent, because of the very nature of their disability, lack the insight, judgement and communication skills to speak effectively for themselves, now or in the future. The advocacy of the Ministry of Citizenship is crucial to ensure that the rights of this especially vulnerable minority group to equity of access, needed services and other basic rights are protected.

Second, the citizens of this province who are developmentally handicapped are being denied equity of access by the public consultation paper Redirection of Long-Term Care and Support Services in Ontario to the provisions of Bill 101 because of the nature of their disability.

Citizens of this province who are developmentally disabled and whose severe or multiple needs necessitate facility-based care are being denied equity of access to this option which is made available to the elderly and adults who are physically disabled citizens of the province in the language and intent of the official consultation document for the proposed legislation.

Policy statements of the Ministry of Community and Social Services, published in Challenges and Opportunities: Community Living for People with Developmental Handicaps, expresses on page 22 its "commitment to the planned phase-out of institutional care for developmentally handicapped people." In the October 1991 consultation paper, Redirection of Long-Term Care and Support Services in Ontario, the Ministry of Community and Social Services provides this option of care to elderly and physically disabled citizens but not to developmentally disabled citizens.

Adults who are developmentally disabled and who require long-term care and special ongoing advocacy for the protection of their rights, because of the nature and complexity of their disability, need the integrated resources of the ministries of Citizenship, Community and Social Services and Health.

The proposed legislation: First, the public consultation paper, Redirection of Long-Term Care and Support Services published by the ministries of Community and Social Services, Health and Citizenship, excludes citizens of the province who are developmentally disabled from the consultation. Nowhere are the needs of the developmentally disabled persons specifically mentioned.

Physically disabled persons, however, are first specified in the preface, before page 1. There are many references to persons who are physically disabled in this document. On page 1, the long-term care and support system is described as "a system that serves elderly people and adults with physical disabilities".

Persons with developmental disabilities with similar service needs are overlooked or deliberately excluded. In either case, they are denied equity of access in the official consultation paper to the provisions of the proposed legislation. These individuals with developmental disabilities surely have a right to equity of access to the same range of service options as persons with physical disabilities.

Bill 101, part IV on page 35, amends the Ministry of Community and Social Services Act to allow the minister to "make a grant to or on behalf of a person who has a disability and who is at least 16 years old, to assist the person in obtaining the goods and services that the person requires as a result of the disability." It also allows the minister to make grants to various entities that have "entered into an agreement with the crown...to transfer the grant to or on behalf of" such persons to assist them in obtaining goods or services they require as a result of their disability.

This amendment would have more clarity and ensure fairness and equality for all those who have a disability if wherever the word "disability" is used in the proposed legislation, the words "physical or developmental disability" are inserted.

The new provisions governing standards, efficiency and accountability in the amendments proposed for the Nursing Homes Act, the Charitable Institutions Act and the Homes for the Aged and Rest Homes Act are commended by the families' association. The association believes that these standards should be extended to include all residential settings, community-based or institutional, for elderly and for persons with physical, mental or developmental disabilities.

The need: We feel that this is very important because of our minority group with very high needs. Persons with developmental disabilities and complex high-care needs who cannot effectively speak for themselves require the ongoing, coordinated services of knowledgeable professionals who understand these special needs. These individuals are very vulnerable to sudden critical changes in their physical or mental states, which must be addressed quickly, effectively and consistently. They also need trained, 24-hour, on-site supervision and individualized daily programs.

The integrated resources of the three ministries: Each of the three ministries—Community and Social Services, Health and Citizenship—has a key role to play in providing ongoing, cost-effective, coordinated, accountable services for all persons in Ontario who are disabled. This is especially true for persons with developmental disabilities with high-care needs. This group includes residents of Oaklands Regional Centre.

The services and continuity of an integrated team made up of the combined resources of Health and Community and Social Services are needed to provide the level of proactive individual care and programming needed by these individuals. This team must invariably include the direct-care staff, the Ministry of Community and Social Services, who interact with the disabled person on a daily basis and then whatever health care professionals are needed by this particular individual. Such professionals will include the family practitioner, the nurse, the dentist, and also the other health professionals as needed, such as neurologist, psychiatrist, psychologist, physiotherapist, occupational therapist, speech therapist and others, such as social workers, all working in concert.

The health care professional consults not only with the disabled person but consistently consults and interacts with the direct-care staff and other team members. The firsthand observations, monitoring and consistent implementation by the direct-care staff of the directions of the team provide the foundation for the individual's overall service. It is the most cost-effective use of the health care professional's time and the taxpayer's dollars. It is also to the great advantage of the developmentally disabled person.

Finally, the special need for the advocacy of the Ministry of Citizenship is nowhere more evident than in the ongoing need to ensure equitable treatment for persons with developmental disabilities and fair access, based on need, to the full range of services made available under the proposed legislation. Accordingly, we believe that the most appropriate and cost-effective approach to meeting the needs of adults with developmental disabilities who require long-term care is through the shared resources of the three ministries, Citizenship, Community and Social Services and Health.

The option of a congregate setting—which we consider Oaklands Regional Centre to be. It is a small, modern schedule 2 facility located in downtown Oakville. The residents live in adjacent houses grouped around a central complex with meeting rooms, swimming pool and gymnasium which are shared with the people of Oakville on a daily basis. It is a community within a community situated on a main street with shops and restaurants nearby where residents frequently visit and are welcomed and accepted. The quality and the extent of the supports at Oaklands for these residents—for example, the coordinating of the multidisciplinary team I just described—would be difficult and perhaps impossible to replicate in the community. It certainly would be very costly.

Immediately north of Oaklands is another congregate setting where 250 senior citizens live in four adjoining subsidized apartment buildings, sharing a park-like setting with the Oakville Senior Citizens Recreation Centre. They also share the Oaklands swimming pool every Wednesday. These senior citizens choose to live there for various reasons, such as convenience, special amenities and services, security and social interaction with groups that share similar interests, abilities and limitations.

There are those who feel that senior citizens should not be ghettoized in congregate settings but should be fully integrated with the younger population. Some older people agree. However, the right of older people to have equal access to either option does not appear to be disputed. We believe persons with developmental disabilities should have the same option.

The option of community-based settings: Community-based programs in Ontario have been, in varying degrees, successful for the majority of persons who are developmentally handicapped. However, it is only in the last three or four years that community-based services for that small minority of adults with developmental disabilities and complex high-care needs have begun. There is no independent documentation of the ability of these programs to provide appropriate or cost-effective care, or indeed of the degree of integration into the community of these persons with developmental disabilities. The association is aware of many residents with psychiatric behavioural disorders who are now at Oaklands after community placements were unable to meet their needs.

Our Families' Association has visited a variety of community-based agency settings in Downsview, the Peel-Halton-Dufferin and Durham regions. We have observed a varying quality of care and programs in these community-based services. We are concerned about the present accountability for MCSS-funded community-based settings. There is a lack of existing standards governing plan of care, professional support services, evaluations and inspections to guide the service providers in the delivery of cost-effective care. Such standards would protect these vulnerable recipients of service as well as the taxpayer's dollars.

For persons with developmental disabilities, living in a community-based setting does not mean that they are capable of participating in its social, employment or recreational activities, nor does it mean acceptance by the members of the community. Social and communication skills are often very limited. Neighbours do not welcome intrusive and often bizarre behaviour from adults.

The families of many of these individuals with developmental disabilities recognize that the more tolerant environment of a congregate setting is a realistic approach to meeting their needs for a sense of belonging, acceptance and the need for social interaction.

The expectation that with more supports families can or should go on providing care for the adult with developmental disabilities is frequently not realistic. It may not be in the best interests of the disabled person or of the family. More long-term care residential settings are needed now and in the future.

Failures in the past to provide appropriate ongoing supports and programs for adults with developmental disabilities and high-care needs have resulted in preventable suffering, disruption and further deterioration. They have also wasted the taxpayer's dollars.

The Families' Association of Oaklands Regional Centre believes that well-designed and well-managed facilities are the most cost-effective and best way to provide the quality of life and standards of care needed by most developmentally disabled individuals with complex and high-care needs. Such facilities should continue to be a part of the continuum of service options available for these persons.

Current legislation, policies and future options statements of the Ministry of Community and Social Services: The Ministry of Community and Social Services' Facilities Planning Project, central region, May 1992, sometimes referred to as the Muldoon-Henson report, rejects the option of facility-based care for persons with developmental disabilities, as did the earlier Ministry of Community and Social Services policy statement Challenges and Opportunities.

The Facilities Planning document does acknowledge the need for some institutional care in the future for some adults with developmental disabilities. For these individuals it suggests mainstream facilities, eg, mental health and corrections and something called "etc." The Families' Association rejects these options as acceptable redirection of long-term care.

The programs in the Ontario psychiatric hospitals or the institutional ones that we know of in Health are geared to a completely different set of needs and intellectual levels. Social interactions among these individuals are frequently and very stressfully incompatible. Moreover, the psychiatric hospital does not provide the daily care, training programs and other services needed by individuals with developmental disabilities and high-care needs.

The Ministry of Correctional Services also lacks appropriate programs and services for this group, with the added limitation of restricted freedom. There is limited possibility of anything but harmful social interaction between the incarcerated offenders and individuals with developmental disabilities.

Moreover, the per diem rates of both of these types of institutions are considerably higher than those of a facility such as Oaklands Regional Centre.

The Families' Association maintains that persons with developmental disabilities must not be denied equity of access to the full range of long-term care and support services options available through the proposed legislation. The option of appropriate facility-based care for persons with developmental disabilities must be included.

The summary, with a quotation from the redirection consultation paper, "the vision of an equitable and caring community": Citizens with developmental disabilities and high-care needs comprise a highly vulnerable minority group in our province. Because of their varying intellectual impairments and because of deficits in communication skills, insight and judgement, they are, with few exceptions, unable to speak effectively for themselves.

They already have or will have most of the same needs as elderly persons and adults with physical disabilities. They also have additional needs of varying complexity which must be addressed by the language and intent of the proposed legislation.

The public consultation paper Redirection of Long-Term Care and Support Services in Ontario specifically includes adults with physical disabilities in its provisions. Nowhere does it address the needs of adults with developmental disabilities. We affirm their right, as citizens of Ontario, to equal access to the provisions for consistent quality and range of needed services, including facility-based care, as those provided for elderly people and adults with physical disabilities.

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Our recommendations:

- (1) That the ministries of Citizenship, Community and Social Services and Health acknowledge the right of equity of access of people with developmental disabilities to needed long-term care and support services provided for elderly people and people with physical disabilities in Ontario.
- (2) That the ministries of Citizenship, Community and Social Services and Health recognize the need of people with developmental disabilities for long-term care and support services in Ontario.
- (3) That the language and intent of the proposed Bill 101 legislation be amended to include specifically people who are developmentally disabled as well as elderly people and people with physical disabilities.
- (4) Very specifically, that the wording of the amendment to the Community and Social Services Act in part IV, section 19 of Bill 101 be changed so that wherever the word "disability" is used it is preceded by the words "developmental or physical."
- (5) That the Ministry of Community and Social Services review its policies stated in Challenges and Opportunities, August 1988, and amend them to acknowledge the right of equity of access of persons who are developmentally disabled to appropriate facility-based care.
- (6) Finally, that the responsibilities for ongoing advocacy and provision of cost-effective accountable care for persons with developmental disabilities who require long-term care and support services be shared by the ministries of Citizenship, Community and Social Services and Health.

The Families' Association of Oaklands Regional Centre asks you to consider our recommendations carefully and to give your support to their implementation.

The Chair: Thank you very much for a very full and thoughtful presentation, and we'll move right to questions with Mr Jackson.

Mr Jackson: First of all, let me commend you for your forthright brief. I'm familiar with the caring and supporting environment at Oaklands Regional Centre. I've been a guest in that home on many occasions.

Perhaps I can get right to the point. Have you received any indication from the Minister of Citizenship regarding your plea for inclusion into this bill, or have you written to the Minister of Community and Social Services either, specifically with an appeal for an inclusion?

Mrs Rhodes: On this day we have forwarded a letter to the ministers of the three ministries, and a covering letter including this brief.

Mr Jackson: We've raised these questions in committee and not really received satisfactory answers, but given that the parliamentary assistant to the Minister of Health is here today, perhaps he might use a moment to clarify why the exclusion is there, and yet we know that the differently abled community whom you represent specifically made presentation in the consultation period on the two occasions prior to us receiving this legislation. So it's not as though the government didn't hear—not your association in particular, but generally advocacy groups for persons with Down syndrome, the developmentally disabled. The point was made during the consultation period that there should be some recognition and inclusion in the

legislation. So it's not as though the government never heard from anyone.

So perhaps, if I might, Mr Chairman—in the rotation if the parliamentary assistant might clarify for these family members' parents, I'll yield the balance of my time and perhaps at the end of the questioning he can indicate just why that exclusion exists and to the extent to which the government may be amenable to re-examining it.

The Chair: Okay, thank you. Ms Sullivan.

Mrs Sullivan: The Oaklands Regional Centre is just a few blocks from my own home and my children have taken swimming lessons there, and I can assure people on the committee that it is very much a part of our town and our community, and that the work that's done there is quite extraordinary and the involvement of the families is quite extraordinary.

One of the things that I have found significant, because cases have come to me in my constituency office, is that thinking over a period of time has changed with respect to community living options. What the board and the Families' Association at Oaklands is saying, as other groups before us have said, is that for those people who can cope with a community living situation and who will thrive in that situation, that's an appropriate venue, but for those who cannot, a long-term care approach with coordinated service plans, with coordinated and centralized specialties, is more appropriate and is indeed the more viable situation.

My understanding was that the ministry was going to consider or had promised to consider the inclusion of the developmentally disabled in terms of proposed amendments to the bill, and I think that certainly was where we left the last presenter. We haven't heard further from the ministry, and I will underline again Mr Jackson's question with respect to where the Ministry of Health, which is carrying the bill, is in terms of that proposal.

I also want to say that this is, once again, an absolutely excellent presentation and typical of the work that comes into my constituency office from Oaklands.

The Chair: Perhaps, then, I'll call on the parliamentary assistant.

Mr Wessenger: Thank you very much for your presentation, and I certainly appreciate your position and your concerns about the whole aspect of generic treatment.

What I would like to say is that this is a policy decision at this stage to only include in the long-term care legislation the elderly and the persons with physical disabilities. I don't think this necessarily precludes the matter of looking at an integrated system in the future. I think it's just a policy decision at this time that perhaps government can only take on so much in the reform at one stage. I don't know whether the parliamentary assistant for the Ministry of Community and Social Services would like to add something because, really, your area is within his jurisdiction. He might more appropriately be able to comment on the other aspects than myself.

The Chair: The parliamentary assistant for Community and Social Services?

Mr Randy R. Hope (Chatham-Kent): I was a little bit intrigued by the opposition's tone of voice about this proposal when I hear them saying now that they want institutions left open. Is that what I hear coming from the opposition?

Mr.Jackson: You heard what was-

Interjections.
The Chair: Order.

Mr Hope: I just listened to a lot of waffling.

Mr Jackson: —answer the question.

Mrs Sullivan: Good grief.

Mr Hope: I just listened to a lot of waffling, so I had to get a little clarification that that's what you're asking for.

Interjections.

The Chair: Order, order. Mr Hope, if you could—

Mr Hope: Well, I just wanted to make sure it was clear over there if that was truly—

Mrs Sullivan: That's shocking. That is absolutely shocking.

The Chair: Order, please. Order, order.

Mr Hope: But one of the things that had been brought up from a lot of the family auxiliary programs—from the Southwestern Regional Centre, from the Rideau Regional Centre, from all of the centres—is where do the parents and the client group play in this whole scheme of longterm care? I know the Ministry of Community and Social Services continues to push that they be a part of the overall deal, but I know there is still phase 2 of the multi-year plan, which was initiated for the downsizing of institutions by the previous government. That phase 2 of that multiyear plan—as we discovered, it wasn't a total plan—has to be re-examined in making sure that the services that we're talking about in the community and the services being provided for individuals are there. So the multi-year plan, phase 2, is a conversation that's continuing to this day. I know that with the previous minister and, I ought to reassure, with the new minister, we act as advocates on behalf of those to make sure that the direct funding model is one that's accessible, that whether it be mental, physical or all disabled groups, they access this funding one way or another. I know we continue to push that area to make sure we don't have a number of plans out there that are always allowing gaps. As you're well aware, there's a multi-year plan that's out there; there's long-term care. Where does everybody fit? The direction I've been hearing from a lot of the family organizations is, "Make sure there are no gaps for us as individuals."

The Chair: If you have a question back or comments, please.

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Mrs Nero: It's more a comment. I would prefer not to refer to them as gaps. I would prefer to say that either ministry, Health or Community and Social Services, should be assuring the families, whether they be in institutions or whether they be at home, that there will be a continuum of service available from those who are able to be supported more independently in the community to

those who need perhaps 24-hour supervision in group homes in the community to those who need the more secure setting of small, well-managed facilities. We don't see, as we said in our brief, any studies that have been done on the existing care that have happened even on the transfers from the nursing homes to the community or from Christopher Robin to the community—the quality of care, that kind of thing.

When we're talking about quality of care, we're talking about a continuum of services. For example, when you hear, "If the nurse doesn't show up, we just call a service and get any nurse," this to us is not quality of care. So we're saying, "Where are the studies that are showing that this is a better trend," at the same time as MCSS is definitely still saying, "We want the hard-to-serve out in the community."

We're concerned, in the Oakville area, that we have a rather unique program for the more psychiatric-impaired developmentally disabled. If you were to close a centre like Oaklands and put these people in the community, the very nature of their illnesses says they're going to be up and down. That is the one given with these people. Where will they go to be stabilized? This is something that you and Health have to get together on to reassure us. There are those who perhaps would be willing to look at some small group homes if they knew the continuum of service was there. So if that sort of explains where we're standing, we need an awful lot of reassurance.

I'm very concerned about those who have kept their children at home and have found, at age 20 or 21, that there is nothing available. Having been somewhat in those positions nine years ago, thank God for the Oaklands Regional Centre. They'd have no place to go. I know how I burned out. It would take a lot more than respite care to help me through those situations. I'm really concerned that you do take a look. So to hear you say that you weren't sure whether you'd find any dollars for them, I would say maybe you have to prioritize whom these dollars are going for, but they certainly should receive some of the dollars that are going to be made available to the physically disabled and the elderly. The need is there.

The Chair: Would you care to comment as well?

Mrs Rhodes: I guess, just returning again to Mr Hope's comment on the first phase of the multi-year plan, or the overall deal in which everyone is to be included, you can't imagine how shocking this was to parents with older children to see some of the statements in this Challenges and Opportunities which just bore no resemblance, in reality, to the needs of our children. Mr Jackson, for instance, mentioned something which we hear a great deal. He talked about the developmentally handicapped and he mentioned persons with Down syndrome and so forth.

There is a widely held stereotype of what a developmentally handicapped person might be. Some of the people who are at Oaklands Regional Centre and in some of the other facilities belong to that special minority. They are people who can not only not live happily but they cannot survive in the community. Presumably, everyone would be part of the overall deal in the first phase. I guess

we are so fearful because of what has been said and what has been repeated in 1992 again, just last year, that there is not going to be a viable option. Not only are there not going to be any more facilities, but then sheltered workshops, group homes too institutional in setting—it's hard to understand what these people are thinking of in these statements.

The Chair: Thank you for coming here today. I think part of what we do also, as you know, becomes a record through Hansard. I think it's fair to say that in the hearing process we've had several parental groups come before the committee and have talked, as you have today, about the needs as you see them and the sense that we're all perhaps on a journey where we're trying to determine just what is the best care we should be providing to all of our people. What you have said today and in your response to our questions, not just in helping the committee—but quite frankly, the ministries as they think through the policy decisions they have to make over the next number of months and years. We really appreciate the time and effort you put into your brief in coming before us today.

Mrs Rhodes: Can I make one more small comment? Mr Wessenger spoke of it being a deliberate policy to exclude the developmentally disabled from this consultation because it's such a big task to do this and there is such a—perhaps some time in the future we'll have to address this and get around to it. But right now the families of Oaklands Regional Centre feel, because of documents such as the Muldoon-Henson report and some of the other things we are hearing from other organizations, do feel quite threatened and quite anxious and the thought of deferment is not very palatable to us at all.

The Chair: Thank you again for coming and making your concerns known to us.

CHARITABLE HOMES FOR THE AGED IN THE NIAGARA AREA

The Chair: I call on the next presenter, the representatives from the Charitable Homes for the Aged of Niagara and Hamilton-Wentworth. Thank you very much for coming to the committee today. Please be good enough to introduce yourselves and then proceed with your presentation.

Mr John Buma: Thank you. We really appreciate this opportunity to come before you and present our concerns regarding the proposed legislative amendments known as Bill 101

My name is John Buma. I'm administrator of Albright centre in Beamsville. I represent one of eight charitable homes represented in this presentation and those eight charitable homes are listed on the paper you have in front of you. Perhaps the other people here might wish to introduce themselves.

Mr Jake Friesen: I am Jake Friesen, administrator at the United Mennonite Home in Vineland, Ontario.

Mr John Janzen: John Janzen, representing Tabor Manor.

Mr Gord Midgley: I am Gord Midgley, representing Heidehof Home for the Aged, St Catharines.

The Acting Chair (Mrs Yvonne O'Neill): Yes, gentlemen, if you'd like—you'd have to come forward to the mike, however, or you won't be recorded in Hansard. Would you like to sit in the chair at the other end of the table for the presentation?

Mr Melis Koomans: My name is Melis Koomans, administrator of Shalom Manor in Grimsby.

The Acting Chair: John, will you be making the presentation?

Mr Buma: Yes.

The Acting Chair: Thank you. Would you begin, please.

Mr Buma: The eight charitable homes we represent include the homes mentioned. Albright Manor in Beamsville is affiliated with the United Church of Canada; Foyer Richelieu home in Welland is a home for francophone Canadians; the Heidehof Home for the Aged in St Catharines is a home for German Canadians; Idlewyld Manor in Hamilton is a women-only home for the aged; Pleasant Manor in Virgil, German Mennonite Canadians; Shalom Manor in Grimsby is for Dutch Canadians of Christian Reformed origins; Tabor Manor in St Catharines, Mennonite Canadians; and the United Mennonite Home in Vineland is Mennonite Canadians. We're about 8 of approximately 80 to 85 charitable homes for the aged across the province of Ontario.

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We've prepared a brief for you which I understand has been given out. This brief outlines the collective opinions of our homes and was endorsed by the board of directors of each of our homes for release and presentation. In addition to that brief, we have a document called Presentation to the Legislative Committee re Bill 101. It's from that document that I'll be making a presentation too, but the other one is more fleshed out in terms of what we're saying.

The amendment act and access to services are one of our primary concerns. In particular, section 9.5 of Bill 101 speaks to access and the whole area of placement coordination. In subsection 9.5(3) it indicates that "the minister shall designate the placement coordinator who may authorize the admission of persons to that home." In subsections 9.5(5) and (6), a person may be admitted (a) if the placement coordinator has determined that the person is eligible. (b) if the placement coordinator has authorized the admission of the person to the home, and (c) an approved charitable home for the aged shall admit a person who meets the requirements of subsection 9.5(5). Subsections 9.5(7) and 9.5(8) reinforce what is said. In subsection 9.5(9) there's a penalty. Where there's continuous or recurring contravention "the director may direct the placement coordinator...to cease authorizing admissions to the home."

In essence, our specific concern related to this is that all these decisions are being made on behalf of our homes in total and complete isolation from our homes. Our homes, in accordance with what it states in Bill 101, are not asked to participate whatsoever in the admission process to the homes we operate. The decision to admit, as I mentioned, is removed from the home. The consumer eligibility is based solely upon government prescription and

subjects the consumers, in our opinion, to another level of bureaucracy at a most vulnerable time in their lives. Most who come to our home come from the hospital or by ambulance, in that kind of way. To think that at that time they would make application to a placement coordination service is a little bit ironic.

In any event, this section of the act—placement coordination—does not provide for any input of the home. As mentioned, there is no recognition of the consumer's needs in the context of the services and culture of our home, to which the placement coordinator is making the referral. We suggest that each individual who is referred is unique and that each home he's being referred to is a unique home in the services it can provide and what it has to offer. None of that is taken into consideration in the amended act as it's currently written, and of course we haven't seen any regulations to this act.

The director can cease authorizing admissions to charitable homes, which in essence means the home would go bankrupt because funding is based on keeping the beds full. In other words, the government has control of the home from the front door to the back door and every step in between. Our general concern in this area is that our facilities are owned by us and our board of directors is legally responsible for the day-to-day operations of our homes. Complete government control over admissions and/or no admissions to our homes, as per the act, through a government-operated broker—a placement coordinator—ignores the legal responsibilities of the community volunteer directors on our boards.

Complete government control over admissions ignores the objects defined in our letters patent, under which we are incorporated by the very same government. We suggest that in the process of becoming incorporated, we had to submit to the government of Ontario objects as to what we wanted to do as an organization, and those objects define whether we're providing service to francophone Canadians or service to religious groups etc. In our opinion, with government assuming complete control over admission, with no recognition of any of that, we believe that there are some problems in that area in relation to how Bill 101 currently reads.

Placement coordination for purposes of admission to a charitable home for the aged, in our opinion, is a third-party eligibility process that is extremely bureaucratic, unnecessary and a waste of the taxpayers' dollars. In the other paper, we have some recommendations and ways of getting around this and still achieving reform in the system etc, and we'd be more than happy to speak on those.

With regard to section 9.6, there's something there called "Immunity" where the placement coordination service or agency will be immune to action from any damages for any decision it makes or doesn't make in good faith. Our specific concern regarding this is that granting the placement coordinator immunity from all decisions made or not made in good faith creates almost, in a sense, a dictatorial relationship between government and consumer. This is done in the context of a time when a consumer is most vulnerable.

We respectfully submit that there is no accountability in a system where those who control it grant themselves immunity from their own decisions. It just doesn't make sense. At the time he requires access, the vulnerable consumer would be unable to hold the government responsible for decisions the government made concerning the vulnerable consumer's needs, only because the vulnerable consumer isn't in a health position to be able to even begin to advocate for himself what he may require.

There is also no accountability in a system where those who make the admission decision to our homes grant themselves immunity from any of the potential consequences of having made the very decision. The legal responsibility, as I say, is left to the home although the home had no say in making the decision whether or not to admit somebody.

Our general concern in this regard: A fully government-funded and completely immune placement coordination service, which makes decisions for a home in isolation from the home and which makes decisions impacting upon the tax paying and contributing competent consumer in a parochial manner, is potentially in conflict with the amount of funds the government has available. If the government controls admissions and at the same time hands out the money to the home to operate, depending upon the availability of the money, I suppose, it could shut the gates at the front end. We respectfully submit that this is a conflict of interest to those who may be needing the services that a home offers.

With respect to the amendment act and access to services, sections 9.7, 9.8, 9.9 and 9.10 of Bill 101, we'd like to make the following comments. Section 9.7 deals with notice of determination, 9.8 with hearing, 9.9 with immunity and 9.10 with appeal to a divisional court.

In section 9.7, "If a placement coordinator determines that an applicant...is not eligible, the placement coordinator shall serve on the applicant a notice of the determination of ineligibility." The applicant then may serve notice and be entitled to a hearing by an appeal board. The decision of the appeal board members would hold, but that decision can be made by the full board or, in its absence, the vice-chair, the chair or whomever.

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Section 9.10: If the applicant does not like the decision of the appeal board, then we can proceed to the Divisional Court on a question of law or fact or both.

First of all, in this regard, we submit that a decision based upon prescriptive criteria issued by government, which has a direct conflict of interest as a financial contributor to the home, in making the decision as to whether or not a consumer will get in relates back to the initial comments regarding placement. What we're basically saying here is that you may appeal something, but again, the appeal board is a 100% government-driven board and that appeal board is in a conflict of interest with the placement coordinator, as it is with the government, in that the government is the funder of the whole thing, so again, it is the assuming of government control.

The applicant who is served notice of ineligibility: It seems unlikely that an applicant seeking to get into a home

for the aged in this day and age would be of such physical and mental health that he would be in a position to proceed to the appeal board.

Under subsection 9.8(5), again there is a potential conflict of interest which is not addressed, which we talked about

The last concern on that page: It seems unnecessary that one would have to protect a decision to admit or not to admit with full immunity status for the person or agent making the decision. Protection behind immunity does not of directors of our charitable homes for the aged have the full legal responsibility for the day-to-day management of our facilities and have no immunity whatsoever for a much broader range of decisions that they must make. It seems ironic that a placement coordinator needs immunity for a decision as to whether or not a person is eligible and to what home he should go when a board of directors, with much more responsibility, isn't receiving any immunity from anybody for anything.

In regard to inspectors, subsection 10.1(5) of Bill 101 outlines the powers of the inspector, including the power to inspect the premises and records, question persons on matters relevant to the inspection, conduct tests or examinations as reasonably necessary, copy or remove records and call upon experts for assistance. Again, for some strange reason, under this bill they too need immunity; another government-controlled organization again requiring immunity for decisions and actions that those people take.

Our concerns: The role of enforcer through prescriptive management and governance by way of inspection seems to take precedence to the traditional role of partner in service. We've been partners up to this point in time. Everything we've done has been collaborative and cooperative and everything has worked well for our charitable homes up to this point in time. For some reason, at this point there seems to be a need to create an inspection and enforcement system, which we're not really sure we understand to begin with, nor why it's necessary, secondly, for our charitable homes.

The role of enforcer by way of inspection, coupled with their immunity status under the legislation, or complete protection to hide behind one's decisions, puts our homes in a no-win position regardless of how well we are governed and managed. It totally strips the right of directors on boards to even manage or direct the homes.

It seems the government prescribes what we must do in this bill, decides how we must do it and then hides behind its immunity for all its prescriptions and decisions. That's the way we're reading the words in Bill 101, without having seen regulations.

Our homes are already currently governed under a significant number of provincial and federal pieces of legislation as well as local bylaws. To be exact, we've come up with at least 25 different acts of the government of Ontario that affect our operation, there are at least eight different acts of the government of Canada that affect our operation, and then there are the local bylaws—board of health bylaws, fire hazard bylaws, housing bylaws, municipalities' bylaws etc—that all affect the operation of our homes. So

inspection and accountability certainly are there when one looks at homes on a more global basis than solely the act under which they operate from a service point of view.

All of this already places a great deal of accountability in the system. In addition, our board of directors is personally liable for a significant number of areas of operation within our homes. That's defined in the other paper, on page 4; I think I've listed about 36 areas in which our board of directors is personally held liable under the various acts by which it is governed. They do not have any immunity status, as mentioned before. In addition, our constituents, which include our church and/or ethnic affiliations as well as our consumers, hold us accountable.

The introduction to our charitable homes of inspectors, including inspection and enforcement officers, together with a backup compliance unit and a backup enforcement unit at head office here in Toronto, is totally unnecessary and, as such, very wasteful of taxpayers' money, and is intrusive to the extreme. These measures create accountability overkill in our homes.

In summary, we, as eight homes, agree with the need for reform in acute and long-term care throughout the hospital and long-term care facility systems and the community-based systems. We agree that there are major ongoing operating expenditure reductions that can be realized without affecting quality of service in the system. We agree with the introduction of a patient classification system and related financing system and the introduction of service contracts with government. We don't have any problem with those things, and we think they're long overdue.

However, we also feel strongly, from our collective perspective, that in order to achieve this reform:

(1) Placement coordination agencies are unnecessary for charitable homes for the aged, a waste of taxpayers' dollars and another layer of bureaucracy. They disempower the consumers at a very vulnerable time in their lives. They in fact are the beginning, in our opinion, of the destruction of the raison d'être for, and the ethnic/religious flavour of, our charitable homes.

(2) The introduction of inspectors, enforcement officers, a backup compliance unit and an enforcement unit to our homes is unnecessary, a waste of the taxpayers' dollars, intrusive to the extreme and potentially in legal conflict with the legal powers of the directors of our homes to operate. The compliance system with full immunity, as proposed, is completely dictatorial, as accountability becomes a one-way street. Presently, we enjoy a two-way street accountability: us to government, government to us and both of us to the taxpayers. We feel this is completely lost under this section of Bill 101.

We have never been in the business of making a profit from our operations. As such, there has been and is no incentive for us to provide anything less in service than our resources allow. We believe that the introduction of placement coordinators and inspectors in this regard completely erases the "partners in care" philosophy so widely touted by the government. While there's merit in standards, it's not necessary to paint our charitable, non-profit, community-directed homes for the aged with the same brush as

the for-profit, shareholder-directed nursing homes. In our opinion, we feel that's what's happening in Bill 101.

We hope that our comments in this paper will be considered to be constructive, useful and of assistance in the finalizing of the draft Long Term Care Statute Law Amendment Act, and we hope that regardless of the final product we will continue to enjoy the partnership with our ministry and our government we currently experience.

1620

The Acting Chair: Thank you very much, gentlemen. Your brief certainly does bring a different perspective. I think you're the first persons who have actually taken sections of the bill and stated your direct concerns, and then put the bill in its legal context from federal, provincial and municipal structures. It's very helpful for us. I think Mr Wessenger has a question.

Mr Wessenger: Perhaps a couple of points of clarification. First of all, your comments with respect to subsection 9.5(6): I noted when you quoted that section that you didn't quote the words, "unless a ground for refusal of admission prescribed by the regulations exists," which would certainly give the right of refusal to a home, and certainly the intention is that the home would have the right of refusal in those situations where there was an inappropriate placement. Secondly—

The Acting Chair: John would like to respond to that.

Mr Buma: We don't have the regulations in front of us and have no idea what those are going to say. We could only comment on what Bill 101 says, and it's silent on that.

Mr Wessenger: Except that it did indicate that there were grounds for refusal.

Mr Buma: We don't know what it means. It doesn't say that. It doesn't say what that is or means; it just says that.

Mr Wessenger: The second point of clarification is your comment with respect to inspectors being immune from liability. That is true. As crown employees they are immune, but the employer, the crown, is still liable. In the words, there's still the liability of the crown, the employer, for any wrongful act or negligent act of the inspector. So the liability still does continue to exist in that.

I'd particularly like to ask you about your position with respect to placement coordinators. The role of placement coordinator exists already in about half the province. Certainly, when we've questioned people in the areas where they've had placement coordinators, they've been very supportive of the way they operate generally, in that first of all they tend to assist consumer choice, enabling the consumer to make a choice as to the most appropriate facility, and also to enable the consumer to have the choice of non-facility care too, if that is appropriate. So having a placement coordinator seems to be an enhancement of consumer choice rather than detracting from it. Also, it's a mechanism for ensuring that those persons with need get priority.

I'm wondering, in view of the intention and the way the placement coordination agencies work as they are intended to work, why you have particular concerns, particularly since, as I said, we have not had concerns expressed to any large extent in any of the areas where they do have placement coordination.

The Acting Chair: It may help, John, if you state whether there's a placement coordination service in Hamilton Wentworth.

Mr Buma: Yes, there is, and also in Niagara.

Mr Wessenger: Does it work well in your area now?

Mr Buma: To my knowledge it does, but we don't use it. Whether the other seven homes use it—I can't speak for them. I should clarify that: We don't use it in its formal sense; there's a loose relationship between us and them.

I'd like to speak to that for a minute, but you mentioned another issue prior to this one, Paul: the liability concern in the crown. There are not too many people who are in a position to take on the crown. That's a very difficult process, as you know. If one could do that, they'd be worth a million dollars. In any event, to bring it up to the crown level as opposed to leaving it right at the placement coordination level and making them accountable, I'm not sure why that's—

Mr Wessenger: I was just referring to the inspection aspect. I think your point is correct. With respect to the placement coordination, there is not, at the moment, other than the employer, which would be the placement—

Mr Buma: With regard to the placement coordination agencies that exist, consumer choice etc. I think you have to understand that in the context of our charitable homes. I mentioned at the outset that, for example, the Fover Richelieu is built and established for francophone Canadians of the Niagara region. It was initiated by them, and built and established for them. They have a large constituency, and there's not one of them who doesn't know that the francophone home exists and, "That's where I'm going to go when I'm ready to go." Chances are that that constituency gave a lot of money in order to build a home, because chances are that the home was built 100% by dollars of the constituency itself. The government operates a program in the home from a cash flow point of view, but often the bricks and mortar of charitable homes are raised 100% by the constituency of the charitable home.

That's perhaps why we don't have too much difficulty filling our charitable homes. The Mennonite people across southwestern Ontario know where the Mennonite homes are and know how to access them, and often there's communication between those homes and their churches and constituents in that way. We're very much different from a municipal home or a nursing home. I won't even speak to the nursing home situation, but we're different from a municipal home in that we have a very strong, very much involved constituency base.

The Acting Chair: Mrs Sullivan, would you like to begin your questions?

Mrs Sullivan: Yes, I would. I appreciate this presentation. I found it a very interesting one. I wanted to explore with you further the question of accountability. Who will sign the service agreement on behalf of your homes? Will that be the board or will it be the administrator? What will

be the accountability in terms of your legal obligations and your corporate obligations, in terms of the responsibility for signing the service agreement and complying with it? How will the board itself, which is made up of people from the community associated with the institution, reflect its accountability with respect to the service agreement?

The Acting Chair: Can you get those all into three minutes?

Mrs Sullivan: One and a half, because I've got a second question.

Mr Buma: You ask very difficult questions. Who signs will probably vary between organizations. Whether boards want to establish a finance committee that signs or delegate that to an administrator would be, I think, up to them, depending on what the ministry's going to do with respect to how it lays these service agreements out. We haven't seen those yet.

With respect to accountability and their legal and corporate obligations, I assume that the service agreements are going to be based upon a patient classification system which derives a case mix index, which is going to relate to the funding we are going to provide. If we have a case mix index of 1.6 and the average in the province is 1.0, and then the dollars are attached accordingly, I suspect—and the ministry people here will be able to answer this much better than I—that we will sit down with the ministry people and develop the service agreement from that.

Now, from our point of view, that service agreement is going to have to be able to be an accomplishable thing before we sign it. If we can't accomplish it because we don't have the money, I think we wouldn't sign it. I certainly wouldn't recommend to the board of directors to sign something when it's not sure whether the funds are going to come in. That's going to create somewhat of a problem.

Mrs Sullivan: I'll give you a scenario where the inspector comes into your facility, makes a report and does not provide you with a copy of the report. Therefore, that report isn't necessarily available to your board. As a result of that report, your funding is reduced. Who's accountable, then, for delivery of services?

Mr Buma: I would make an argument under Bill 101 that, because the government has assumed complete, full control, it's accountable. I would argue that the way Bill 101 reads, without seeing regulations, without seeing service contracts, they are putting themselves in a position of potential problems, and they don't need to accomplish the same reform they wish to accomplish.

1630

The Acting Chair: Mr Wilson, you have some questions?

Mr Jim Wilson: Thank you, Chair. I think this is an absolutely excellent presentation. You've put a lot of work into spelling out for us your specific concerns with various sections of the bill and I thank you for that.

I'm going to ask you a general question because I think I understand most of the points contained in your brief. Having served on a board of directors myself in an educational

institution, but not in a homes for the aged, I know of the responsibility that individual directors take, and it seems to me that with increasing piles of legislation going on the books every year there's more responsibility on these people. Do you think that if the government—I say "the government" because it is responsible for this legislation—doesn't do something to correct the problems with consumer choice and facility refusal and facility choice and some of the other concerns you've raised, it may be very, very difficult to get people to even serve in a volunteer capacity? Would anyone like to talk about that?

Mr Janzen: I'd like to address that, if I may. This is one of our major concerns. Here we have privately owned charitable institutions that have, due to need, put up a facility, have operated for many years and have long waiting lists representing the people who actually own the place, now in a position where those boards of directors can no longer accept the people who actually own the place.

As a matter of fact, the decisions will be made by the agency as opposed to the board of directors. That will have a tremendous impact on the future of that home. For example, it will destroy the right of the owners to determine who will be admitted or whether they can serve the people who have actually put in their money. It's going to put a tremendous burden on that board of directors to raise funds, whether it's for ongoing purposes or future expansion.

Some of the homes have just recently spent a great amount of money on upgrading, realizing that when their turn comes they will have access to the home. This holds true for most of the eight homes we're talking about.

There's a tremendous amount of volunteer work that goes into the operation of such a home. If these volunteers and the constituency they represent now realize that they will not have access to the home, that will dry up. Not only will the funds dry up, but also the volunteer work.

As a matter of fact, it pulls the rug on the elected board of directors to operate the home as its constituency would want to see it. The long-term impact of this legislation spells the end of charitable institutions as we know them today.

Mr Buma: I might add that if I were asked to be a director on a board, under this piece of legislation as it now reads, knowing my personal liability as a director on that board, I would have great difficulty saying I would agree to sit on this board, because I would find myself in a conflicting position of being legally responsible with no corresponding authority to do anything. That just doesn't fit the bill.

Mr Jim Wilson: I appreciate it. I don't think I'll ask any more questions because I think you've done just a super job of stressing the importance of amendments that must come forward from the government and from ourselves to clean up this piece of legislation. I parallel your concerns with some of the private sector who feel they are being usurped in terms of maybe actually losing their businesses, while you're going to lose control over the good work you're doing on behalf of your communities.

The Acting Chair: Thank you very much, gentlemen, for bringing us your firsthand, day-to-day experiences

about Bill 101. We hope we will be able to attend to those as we continue our discussions.

IDLEWYLD MANOR

The Acting Chair: May I have the presenters from Idlewyld Manor, please. If each of you would like to introduce yourselves, that would be helpful for Hansard, and introduce your spokesperson.

Mrs Mary Lou Dingle: May I introduce everybody? **The Acting Chair:** Yes.

Mrs Dingle: My name is Mary Lou Dingle. I'm a Hamilton lawyer who restricts her practice of law to wills and estates. I deal very much with the elderly in my practice. I'm also a director of the local Victorian Order of Nurses in Hamilton. One of VON's programs is placement coordination.

The reason I'm here is because I'm one of 15 volunteers who serve on the management board of Idlewyld Manor, which is a charitable home for the aged established, even before I was born, in 1846.

You're not funny. I can tell we're not going to have any fun

Mr Jackson: Mary Lou, it's the end of the day.

Mrs Dingle: It's the end of the day for me too.

Idlewyld began its mission to elderly ladies in 1877, more than 100 years ago. Actually, Pat and I figured a minute ago it was about 116. Right now, Idlewyld is home to 101 elderly lady residents.

With me are Patricia Howell—Pat is my neighbour but she's also the president of Idlewyld's management board—and Daniel Oettinger, our administrator at Idlewyld. They're both ready to answer questions for you. While I present, they have to answer the questions.

Mr Daniel Oettinger: It's fair.

Mrs Dingle: It is fair. I believe Dan has written material to hand out. Has it gone? You already have it. Good. My job then is to highlight and summarize our concerns. I'm not going to follow Dan's paper altogether. I hope I'll make it a little more personal for you.

Our concerns fall into three major categories: first, choice—I know you already discussed that minutes earlier; second, funding the care levels; and third, governance.

Beginning with choice, I'd like to tell you a little bit about my mother. She's 88, and five and a half years ago she applied to be admitted to Belmont House, which is a seniors' residence in Toronto. Perhaps you know of Belmont. It houses 190 people.

I think the reason mother did that was because she wanted to stay in Toronto. She didn't want to move to Milton where my sister lives, although I guess my sister can vote for some of the people here. She didn't want to go to Hamilton either, where I live. In other words, she wanted to stay in her community, which is not unusual.

She also preferred the company of her peers to the increased isolation and loneliness she was sure to experience if she stayed on in her own apartment. Finally, she wanted to maintain her independence. In fact, she sent us a change of address. We were very grateful.

It isn't a funny group. Oh, dear. One of the things I'm known for is having some fun when I'm speaking, but obviously we're on a different wavelength, my darlings.

My mother chose Belmont, and at that time I became acutely aware of the fact that not everyone is best served at home. I mention mom because she's my best friend, but also because I think we have to recognize the value in the alternative lifestyle. In other words, there are people who benefit from a seniors' residence like Belmont in Toronto, or Idlewyld, which is the board on which I serve.

Interestingly, having chosen Belmont, it then was up to mother to fit into Belmont. I'm happy to report that she has finished organizing the residents' council and she still is the chair of the reception committee for new people coming to Belmont. Of course, she's only 88 and she can hardly see now, but once a volunteer always a volunteer. What can I say?

That brings me to Idlewyld. I think probably the single most important element of Idlewyld's success over the last 116 years is the fact that our residents choose us. Our admissions policy selects reasonably fit elderly ladies who want to make their home at Idlewyld. That, I think, is really the gem of the whole thing.

What worries us about Bill 101 is that it proposes to replace our Idlewyld admissions committee with placement coordination. Placement coordination has a wonderful name in Hamilton. I told you already that I serve as a director of the VON, and placement coordination is one of the VON programs. In fact, placement coordination, for those of you who don't know, was created by Dr Ron Bayne who is a neighbour of Pat's and mine. We can all see his garage from ours.

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As a lawyer, I use the service repeatedly because I can refer clients, and their job is to assess the client from a physical and financial point of view and narrow the facilities in the Hamilton area that are good for the particular person. So it's a magic program. But you can imagine how the 15 ladies on the board of management at Idlewyld react when we're told that placement coordination may well have the choice rather than our admissions committee at Idlewyld. We feel this is very inconsistent with the principle of self-determination, to say nothing of our partnership. That's our first point: choice.

The second point is funding care levels. We must have some fun on this or else I'm going home. Bill 101 requires us to assess the needs of our residents on an ongoing basis and to implement any changes required to meet those needs. Of course, that's what we do. That's our job. We do that all the time right now. We don't have any trouble doing that. But just like at my home, and I assume at yours, there are more needs than there are dollars, so we survive financially by establishing priorities. In other words, we manage. If the needs are being determined by government, then I think government has to fund the needs and the changes required to meet the needs.

It might be that government should be rethinking some of the requirements, and I'll come to that in two examples. One is residents' washrooms. We understand that the mandate will be that the residents' washrooms be cleaned daily.

Now at Idlewyld, two ladies share a washroom. They each have their own room but they share a washroom. If we must clean these washrooms on a daily basis, we estimate that we'll have to add 1.4 staff people. As I said to Pat, I think we should hire a man. But in any event, be that as it may, the fact is that it will add to our payroll and if it adds to our payroll, somebody has to help us pay, because it's either the residents or it's going to be government; it's one or the other

I just would like to address how often all our washrooms are cleaned. I live in a home with two teenage sons and a husband, and our washrooms are cleaned twice a week. I think some of these requirements may be excessive, and in a time of restraint they should be looked at. Certainly, at Idlewyld some of the washrooms are cleaned on a daily basis. We select what has to be done. That's what management and priorities are about.

The second matter that comes to mind is the requirement for a dietitian. Again, this is in standards and I realize they're proposed. But at the present time we have wonderful meals at Idlewyld, which is why I'm so round. We have a dietitian who serves us between eight and 16 hours each month. This seems to be a very sensible and adequate arrangement for Idlewyld. We understand that if the new standards are imposed, we will require 50.5 hours of a dietitian's time on a monthly basis because it relates to the number of residents. Again, we're concerned very much about funding to government standards.

Bill 101 also provides for inspections. Inspections are a little bit like motherhood. Of course we support inspections: They're part of life as we see it; they have a purpose. However, we have trouble supporting inspectors who can inspect, find us wanting, impose sanctions, and all of this without even submitting a report outlining the findings and without any appeal mechanism. We just feel that's very heavy-handed. Again, we're concerned about the partner-ship principle.

Let me then go on to our third point, which is governance. Idlewyld was created by members of the local Hamilton community in 1846, and it has been governed by members of the local Hamilton community ever since. We are getting tired, however.

No? I gave a couple of speeches for Hydro, and it was exactly the same. When I talked about the number of trucks we had, nobody laughed.

Mr Jackson: This isn't theatre, Mary Lou.

Mrs Dingle: I'm the Ontario Hydro rep on our local hydro.

The fact is, there's a mutual need for Idlewyld. The community needs us and we need the community; we need governors from the community. Idlewyld requires the community as the community needs the residents.

In the fall, residents and board members hold a tea. It's a little bit like an elderly lady calling her daughter and saying, "Gee, I'd like to entertain the rest of the family and maybe some of my friends, and will you come and help me?" It's a wonderfully successful tea party. I'm not very good at it because I can't cook, but in any event, it works wonderfully.

On Christmas Day, the tradition is that the president of the management board and her husband, should she have one, go to Idlewyld and serve sherry to the ladies who are staying at Idlewyld for Christmas dinner. All of the residents are visited by members of the board at Idlewyld. In fact, and this is something that my mom mentioned to me, apparently they do the same thing at Belmont here in Toronto. She said that's something that's very important to the residents, because they're all recognized by name by the board members.

In case you don't know, volunteers are fragile. I once resigned prematurely from a board—now, you must laugh at this—because the incoming president's voice was so high, I didn't think I could stand it for two years, so I resigned, and it was a very sensible thing to do. But as a volunteer, you get those choices. I mean, you can even leave here if you want.

But I think it's important for you to know that volunteers evaporate when their authority is eroded, when their leadership is usurped, when their judgement is continuously challenged and when their progress is thwarted. I don't think government should intrude unnecessarily. It's inconsistent with the principle of partnership.

So let me conclude and summarize by saying that, one, government should keep what works: Let the consumer choose. Idlewyld's success strongly relates to choice. Two, government must be willing to finance the changes required to meet the standards it intends to impose. Three, government should nurture and respect the partnership principle, volunteerism and local governance.

I thank you, and my friends are willing to answer questions.

The Acting Chair: Mrs Sullivan, would you like to try?

Mrs Sullivan: Yes, thank you very much. That was a fun presentation, I must say.

Mrs Dingle: Thanks.

Mrs Sullivan: I was very interested in the discussion you had. I think your presentation follows very well on the previous one, because you're dealing with many similar issues. But I was very interested in your discussion of the washrooms and of the dietitians, and I'd like to know how involved you have been in terms of commenting on the kinds of standards and regulations and requirements that are going to be made of homes.

My understanding is that many of the rules are taken from a completely different jurisdiction in a completely different context, that they make no sense in terms of operating here; that indeed the cleaning aspect, by example, is one where a square footage component, which bears no relationship to the patient care requirements or the cleaning requirements, is what's on the table. Can you talk to that? I just thought it was very interesting to hear you raise those two issues.

Mrs Dingle: I'd ask Mr Oettinger to respond to that.

Mr Oettinger: In my role as a member of the executive of the Ontario Association of Non-Profit Homes and Services for Seniors, I personally was involved during the summer for hours and days and days on end, it seemed—I

think Geoff will attest to that—in developing a standards manual which is to be used by all long-term care facilities. So certainly we did have a lot of input into draft 1 of that manual. Draft 2, unfortunately, bears limited resemblance to draft 1, where there was, we felt, very much a collaborative and consultative approach.

There have been a number of unilateral changes on the part of government to that manual. Some of the kinds of things that Mary Lou just alluded to we felt were in non-enforceable guidelines and criteria, and they have now been moved into standards. Regarding the dietitians, assuming that draft 2 were to be implemented in its present form, it would require the 50.5 hours of dietitian time. My dietitian told me today that there is simply nothing for her to do for 50 hours a month. It's an absolute waste of time.

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So we have had extensive input into the process up to this point, and certainly we would hope that some of these things will be flattened out by the time it actually comes into force.

Mrs Sullivan: The issue is one that's of interest, of course, because the funding question is one that will affect all of you. If funding is not adequate to cover the additional costs, then where are the nursing homes or homes for the aged in terms of delivery of fundamentally required services? We haven't seen draft 2 of the standards manual, am I correct?

Mr Ouirt: That's correct.

Mrs Sullivan: Will we see draft 2 of the standards manual before this committee has completed its hearings?

Mr Quirt: Part of the second draft of the manual has been shared with members of the committee as well as with OANHSS and ONHA and our manual advisory committee. The second draft of those particular program standards has been shared. On March 15, there's another meeting scheduled with that manuals committee, including Dan. It's actually a two-day meeting to review all the contentious areas with respect to program standards and other aspects of the manual.

Mrs Sullivan: So there's a possibility that what is on paper now with respect to cleaning requirements or dietitians or other standards will still be adjusted, that the accommodation of the industry and the sector will be taken into account?

Mr Quirt: The whole purpose of the consultation and the two-day meeting is to make improvements in the manual, yes.

The Acting Chair: Mr Quirt, did you suggest that some members of this committee have that second draft and others don't, or did I misunderstand you?

Mr Quirt: All members of the committee received a first draft of the manual on the second day of the hearings, and all members of the committee received, I believe in London, Ontario, the second draft of the standards section of the long-term care manual. All the new material that is being produced and shared with provincial associations is being shared with the standing committee at the same time, including the materials that were used recently in the

two-day presentation to OANHSS on funding arrangements and accountability relationships.

The Acting Chair: Thank you. Mr Jackson.

Mr Jackson: Mary Lou, welcome. I enjoyed your brief and your humour, as I always have. Never having met your mother, I feel that I get a really clear sense of the kind of person she is, having known you for 15 years.

Mrs Dingle: McMaster '26.

Mr Jackson: A delightful presentation. We have heard, in generic terms, this whole issue of cultural sensitivity to the residents. You bring a very unique focus, gender-specific. This has not really been raised, even when services for retiring sisters of various orders and so on are being discussed. The government has given a careful statement that it would consider these kinds of requests and concerns about cultural sensitivity, which could be ethnicity or could be a faith basis. I've only missed two halfdays of all these hearings, and to my knowledge, I don't think the gender concept has come up.

So with your permission, and through the Chair, I would like to ask if the parliamentary assistant or legal—I see legal counsel has abstained for a moment; maybe Mr Quirt will respond—if there is anything that legal counsel of any ministry has advised you that would prohibit the inclusion of a gender-specific protection for a facility. I'm asking you if you've been given legal advice that you can't do this. I know what kind of answer you're going to give me, about your warm and fuzzy "We'll look at it"; I want to know specifically, for the record, if you've been given any legal advice that you cannot protect—we may as well call it what it is—gender exclusivity.

Mr Wessenger: I'll ask legal counsel to respond to that question. I don't know whether legal counsel heard the question: Is there anything that would prohibit ensuring that a gender-specific home like this Idlewyld remains gender-specific?

Ms Gail Czukar: My name is Gail Czukar; I'm a lawyer with the Ministry of Health. Of course the obvious piece of legislation that would apply would be the Human Rights Code, and it has primacy over all other legislation, not to mention the Charter of Rights, of course.

My view would be that there's very likely a way to structure a preference if it could be construed as an affirmative action program essentially, but it would have to be that in order to attract protection under the Human Rights Code. Otherwise, the rule would be that people who are going to be served in a facility should be served equally.

Mr Jackson: I'm sorry I have to rise to the bait, but as you probably know, we have a disproportionate number of women to men who are surviving to this age. Therefore, to use the argument you're suggesting, which in my view is a back-door way at best, presents several problems, as we're dealing with a facility that's already 100% female.

These are legitimate concerns, given that the cohort of potential clients can include ex-psychiatric patients and people experiencing psychiatric difficulties, and when you inject the gender uncertainties into that mix, this is cause for great concern, not just to the board of directors but to

the residents themselves, as this is a completely foreign experience, or would be deemed a foreign experience, in the retiring years.

Could I hear from the parliamentary assistant, then, having heard a legal opinion, what he, if anything, is prepared to do or offer in terms of responding to what is, in my view, a rather genuine request which is placed before this committee on International Women's Day?

Mr Wessenger: The only thing I could say is that certainly I would think you could have a policy direction to placement coordinators to not make inappropriate placements. It would certainly be considered, in my opinion, an inappropriate placement to place a male in a seniors' residence that is designed exclusively for women. Of course, as far as someone going to court on the matter is concerned, that I'll leave to legal counsel, but I'd certainly give my assurances that I can't imagine any placement coordinator making such a decision: to place someone of a male background in a women-only home for the aged.

Mr Jackson: In the absence of the legislated guidelines, it could occur.

Mr Wessenger: As I said, a lot of things happen on a policy basis in the way institutions operate, and I don't think this legislation in any way changes the existing situation with respect to the matter of a male trying to get into the home. It in no way changes the legal situation.

Mr Jackson: On the contrary. I don't wish to be argumentative, but clearly you are taking the responsibilities of admission away from the current arrangement, which is the consultation of a placement coordinator with the board of directors, who approve and admit the intake, to a system where the government is the gatekeeper and determines, with the only appeal currently being that you have the right to appeal that you were turned down; and the choice is limited to the fact that you can choose not to go into a facility. I can't accept your statement that nothing's changing.

1700

Mr Wessenger: As I understand it, there's no appeal process with respect to the question of where a placement coordinator—for instance, to take the theoretical situation of a male who makes a choice, say he wants to go into Idlewyld Manor and the placement coordinator refuses to place him in there. I don't see that he has any right to appeal against that, because the only question that is appealable by the placement coordinator is the question of eligibility for institutional care and not the question of where he's placed in accordance with his choice.

The Acting Chair: Mr Quirt wanted to make a statement and then we will have to move on to the next caucus.

Mr Quirt: Just very briefly, I'd like to reinforce that it is the job of the placement coordinator to allow a prospective resident to make an informed choice. As is the case now, the only people who would be referred to your facility would be people who have said, "I'd like to go there." If in fact a man were to say now that he wished to move into your facility, you might well have an argument from a human rights perspective. In no way does Bill 101 change that. If under the new system a man were to insist to the

placement coordinator that he wanted to be considered for your facility, it would be the job of the placement coordinator to inform you of that, and that debate would be joined as it would be now if a man were insistent on moving into your facility.

Mrs Dingle: In fact, Belmont House has both men and women—many more women.

The Acting Chair: All right. Did you want to have one short statement?

Mr Oettinger: Could I make one final comment to Geoff's comment regarding the coordination, that it's the job of a PCS to coordinate: We would not disagree with the coordination. I think the issue of control is spoken to very clearly in this bill. I would refer you to section 9.5, where a person may be admitted to a charitable home if, and only if, approved by the placement coordinator. That smacks of control, not coordination. We would have no issue with the coordination part. As a matter of fact, we do so already, in reference to Ms Sullivan's question of a while ago. The coordination we take no issue with; it's the control that we have concern about.

The Acting Chair: Mr Owens, you have some questions.

Mr Owens: My question is to ministry counsel. In terms of a clarification around whether a male would be eligible for admission, I'm not quite sure that I understood the response. Are you suggesting that if a male wanted to gain admission to that facility, he would have grounds on a human rights complaint to gain admission? Is that what I understood you to say?

Ms Czukar: No. I'm saying that the Human Rights Code has a provision which allows for what we commonly call affirmative action. Those aren't the words in the code, and I don't have it here to tell you what the exact words are, but he would have an argument. How it would be settled is not known at this point because it hasn't been contested. It could equally be contested in the ethnic homes or religious homes, any ground of discrimination under the code. Someone could take a human rights complaint that he was refused admission to a home on a ground that's not allowed under the code. That hasn't been tested, so it's hard to say how that would be worked out. I'm just saying the argument that would be made by the home would be that this is an affirmative action or whatever the term is that allows preferences for certain minority groups, or in this case a majority group, on the basis of historical discrimination. That case would be played out in the courts. I wouldn't venture to guess what the outcome would be. I would think in some circumstances it could be justified, for all the arguments that were probably made here, and in other circumstances it might not be justified. We don't know the answer at this point; it hasn't been tested legally. But those would be the legal arguments on each side.

Mr Owens: Thank you for the clarification. Mary Lou, thank you for your presentation. I don't live beside you, but I probably drove by your home at some point, so you can count me as somebody who may know—

Mrs Dingle: Did you know because of the state of my bathroom?

Mr Owens: I want to tell you something: If you get to clean your bathroom twice a week, you're doing a hell of a lot better than most of us in this committee.

Mrs Dingle: I didn't say I did it.

Mr Owens: I'm interested in your comments with respect to volunteers. I think volunteers play an important role in the care of not only seniors but other individuals in long-term care facilities and those individuals still living in the community. I wonder if you could clarify for me in terms of your concerns about the erosion of the volunteer as a result of the passage of Bill 101. I'm not quite clear.

Mrs Dingle: I thought I was making it clear. It seems to me that, as managers of Idlewyld, we make decisions. for instance, about hiring our dietitian, the amount of time we think is appropriate, how often our washrooms are cleaned, that kind of thing. If suddenly we're meeting standards that are imposed by a guide, then we're not making those decisions any more; all we're doing is working to a government standard. You're taking away our management, you're taking away our prioritizing, you're taking away how we spend our dollar—and that's, after all, what it's all about—so it seems to me then that you are removing leadership from us, you're removing management, and you're generally making us feel as though we're not making the decisions but you are, and that, I think, is the danger. In other words, volunteers are only going to work when there's an interest and they feel there's a challenge that they can do well and have a result from. If everything is government-legislated, then I think volunteers will lose interest, at least in that area.

Again, it's very interesting, because I understand the figure being talked about is that about 80% of the care giving is done by women in the community—by women.

The Acting Chair: Thank you all very much for coming today and trying to lighten things up a bit for us. This isn't the easiest bill in the world and you let me know we're dealing with some pretty serious matters. Maybe that's the guise we have sort of set ourselves in. We have certainly enjoyed your presentation and you presented it from obviously a very different perspective again. This whole discussion we've just been ending with is new to Bill 101. It's surprising that after, what, three and a half weeks of hearings, we still are having very new matters brought before us.

Mrs Dingle: It's wonderful work for the lawyers.

Mr Oettinger: Thank you. Mrs Dingle: Thank you.

CHO NETWORK OF ONTARIO

The Acting Chair: If I may have the CHO Network of Ontario representatives, please.

Mrs Sullivan: Madam Chairman, while the next presenter is coming to the platform, it appears that the clerk does not have a copy of the draft 2 standards. I wonder if we could ask the Ministry of Health officials if they would bring that copy for members of the committee tomorrow.

The Acting Chair: I understand that's already under advisement and the clerk is going to do that, Mrs Sullivan.

Mrs Sullivan: Thank you.

The Acting Chair: If you would like to introduce yourselves and begin.

Mr David Murray: Okay. My name's Dave Murray and I'm the secretary treasurer for the comprehensive health organization network of Ontario. This is Sue Goble and Sue is the president of the network.

We represent the members of the CHO Network, and the CHO Network is made up of six different sites which have formally been recognized by the Ministry of Health and are in different stages of development. The sites are the group health centre CHO feasibility study in Sault Ste Marie, the Rainy Lake health studies program in Fort Frances, in the Rainy River district, St Peter's seniors' CHO feasibility study in Hamilton, the Toronto Multicultural Health Partnership in Toronto, the Trenton Memorial Hospital in Trenton and the Wawa and area comprehensive health organization. These represent both rural and urban communities whose populations include those with varied cultural and ethnic needs and preferences.

The CHO Network fully supports the government's resolve to finally reform the long-term care system in Ontario.

The presentation I'm giving isn't the one that's in front of you, so you don't have to bother trying to read along.

Mr Jackson: Is it the same one from Thunder Bay?
Mr Murray: A little different than the one in Thunder Bay.

Mr Jackson: Okay. That was good too.

Mr Murray: Here's the one from Thunder Bay.

Mr.Jackson: All right, I remember that one.

Mr Murray: In the broadest terms, CHOs will take responsibility for the delivery of services to a locally defined population. This population will make up their roster. Therefore, CHOs will work in partnership with physicians, acute care hospitals, chronic hospitals, in-home services, homes for the aged, nursing homes and community agencies to support the needs of the local community.

The CHO Network recognizes that the way to meet the increasing needs of the aging population is not necessarily by adding more beds, or more hospital beds more specifically. More of an effort must be made to forging links with community-based care givers. The CHO concept reflects the changing view of our health care system in focusing on health rather than illness. Health services will be provided in the least intrusive manner, using the most efficient and effective delivery possible. The CHO Network strongly believes in the need for a coordinated continuum of care in Ontario. One of the key objectives of long-term care reform must be to create closer relationships between care providers. As I had mentioned when I was in Thunder Bay. the CHO model seeks to do for all the people in our catchment area what long-term care redirection is trying to do for the elderly.

The continuum of care as put forward by the Honourable Frances Lankin on February 1: "What we are attempting

to do is understand that there really is a continuum of care that is required, and while we have pieces of it in Ontario now, we do not have good linkages and we don't have the sense of the continuum, that people can enter and exit various points of the system at appropriate times to get the care that they require at that point in time."

The network totally agrees with the minister's comments. There is a compelling need for a well-coordinated approach, community by community, to help improve upon that continuum of care for people. The CHO system is designed to simplify and make more cost-effective the administration and funding of health care. By design, the CHO system demonstrates cost containment, restructures and reallocates dollars and resources with reduced emphasis on institutional care, enhances community and consumer participation and represents decentralization and a devolving health system delivery. CHOs are in keeping with the ministry's direction of health care reform.

The former minister had previously made a commitment to the continuum of care embodied in the CHO system. Under the proposed legislation, the ability of a CHO to provide or purchase services in a continuum will be greatly undermined. In short, Bill 101 puts one segment of the continuum under a completely different set of rules. Major changes must be made to Bill 101 to ensure that the philosophical approach used to govern long-term care does not present a barrier to providing that continuum of care now and in the future.

The CHO Network agrees with the minister's five stated policy objectives for Bill 101. The network is, however, very concerned with the approach the government has adopted to achieve these objectives. I'll ask Sue to talk about the key problems and recommendations of the CHO Network.

Mrs Susan Goble: Briefly, we've identified five areas of concern. They're in detail in the brief that we've given you today, but I'd like to summarize them. The first one is the shift to a contractual model from an insurance model, which we see as a problem; the increased expectations regarding levels of care without the necessary resources to go along with it; the placement coordinator role, and we've just listened to two previous presentations that certainly highlight that; fourth, the inspection role and the potential adversarial situation that this might lead to; fifth, the need for the long-term care facilities to determine their own role.

As a network, our major concern is that the legislation appears to set up restrictive sets of rules and regulations to deal with long-term care redirection which are not in keeping with efficient and coordinated care.

We'd like to provide the following recommendations. Under governance, the CHO Network strongly recommends that the government adopt the same philosophical approach to the governance of long-term care facilities as it has to the rest of the institutional sector in the health care system.

At present, some chronic hospitals and nursing homes in communities have set up community advisory boards made up of consumers, families, interested citizens and providers. CHOs, comprehensive health organizations, will have a similar governance structure, which we believe will not only improve the quality of decision-making but will foster increased responsibility by members for their own care. The CHO Network believes that the new long-term care institutions should maintain similar governance structures to those that are currently in place in acute and chronic hospitals and homes for the aged. Only this approach supports the concept of a continuum of care for the consumer.

Under peer review and accreditation, the CHO Network recommends that compliance management, peer review, accreditation and continuous improvement programs be the approach used to ensure accountability in long-term care facilities.

Equity in funding: It is time to distribute the funds equitably between nursing homes and homes for the aged. However, flexibility must be given to those facilities to enable them to utilize their resources as effectively as possible.

Placement coordinator: Not all levels of care can be offered in one facility. Therefore, it is important to people that those who assist in the placement need to recognize the unique needs of the individual and ensure that the placement is appropriate. The range of services in facilities is extensive, from social types of situations all the way through to specialized facilities, such as chronic care hospitals, which have created a multidisciplinary approach to care. Today, many facilities have increased their specialization and have created this multidiscipline approach to meet the changing health and social service needs of the consumer.

The placement coordinator must recognize that a wide range of highly specialized programs, both inpatient and outpatient, have been established in chronic hospitals, and these do not currently exist in either acute care, nursing homes or homes for the aged.

Placement coordinators must further be able to consider an individual's needs with respect to ethnicity, language, geography and religion when placement choices are to be offered. In the CHO system, to ensure that the widest possible spectrum of services are covered, the CHO must provide a full range of vertically integrated services to its members and as such will be able to match the consumer need with the appropriate inpatient or outpatient service.

In summary, there are many challenges facing our health system. The CHO system presents both opportunities for its sponsors and the rest of the local health care community to address today's challenges on the community's own terms. In addition, CHOs provide opportunities for health care providers to become part of that continuum of care.

There are certain common elements between the CHO and the proposed plan to redirect long-term care and support services. Both emphasize service coordination for consumers and effective use of financial and human resources. The CHO program and the long-term care division have developed a policy statement defining how a CHO may be used to deliver long-term care services. The initial focus will be on a coordination and delivery of in-home services.

In developing a reformed long-term care system there must be a properly structured, well-coordinated, integrated

system of community and facility services which can improve the range of choice and enhance the quality of life for the elderly and people of all ages with disabilities so that they can live with dignity and have as much independence as is possible.

The CHO model is the most comprehensive model currently being explored, combining all the elements in the health care system under one governance structure. CHO communities have spent thousands of hours addressing the effectiveness, efficiency and efficacy of this model for their people. This has been done in good faith with the government. Now, given the dollars spent, use of resources and the commitment of both the government and several communities to the model, it's time to take another serious look at the CHO model.

In conclusion, we believe that the legislation, as drafted, would dramatically alter the current system and in our view would seriously impair our ability to manage the overall system effectively. In our opinion, the key to a workable legislation is one that ensures sufficient flexibility in order to reflect local factors and realities. Major changes must be made to Bill 101 to ensure that the philosophical approach used to govern long-term care facilities does not present a major barrier to providing that continuum of care for the health care consumer today and tomorrow.

1720

The Acting Chair: Thank you very much, Mrs Goble. Mr Jackson, I think you're to begin.

Mr Jackson: Thank you for your presentation. We had an opportunity to raise some specific questions about the CHO development in northern Ontario, and for those of us who had not had prior exposure to it, it was quite informative.

I guess at this point, then, my question would be, to what extent are you getting feedback from the designated groups to consult with the infrastructure for Bill 101 and how you might become a comfortable fit into that process? Do you understand what I'm asking you?

Mr Murray: Not really.

Mr Jackson: All right. Under the legislation they will be developing a series of—the buzzwords change from the Liberals to the socialists, so I'm having trouble—

The Acting Chair: Multiservice—

Mr Jackson: Thank you—multiservice organizations.

The Acting Chair: Multiservice agencies. Mr Jackson: Multiservice agencies. MSAs?

The Acting Chair: I think that's what they're using. Is that not the correct—

Mr Jackson: Is that the one we're using this week? Very good, we have consensus here.

Apparently, some groups have already been approached, such as DHCs, to develop how these models could be implemented. My question is, to what extent are your agencies, through your network, being involved in that process of consultation? It's one thing for you to come and present to us, but our understanding is this process is already begun, in a fashion, at a community level. So you should talk to us, but how are you linked into the groups

that are already coming together to advise this government about implementation of this legislation?

Mr Murray: For long-term care, I think that changes community by community, depending on where the CHO models are being developed. I know in our particular community, which is the Rainy River district, the long-term care office for the region, which is in Thunder Bay, looks to utilize the CHO in the area as its coordinating agency, and that's something which we have been discussing with them for close to two years now.

Mr Jackson: I'm sorry to interrupt. We're familiar with that because you gave a very clear—you responded to this question for Rainy River. I guess my question was more to your network of Trenton, Hamilton, Wawa, the other organizations to which you refer in your brief. To what extent are they being invited to the table? Clearly, but I just wanted to get a snapshot of what's happening in the other jurisdictions.

Mrs Goble: I think that specific question has not been collectively addressed by the membership, so I feel a little uneasy in speaking for a group of six people on a specific answer, but I guess in the sense that in no community where a CHO is being explored is there not dialogue and communication ongoing that does not include not only the defined population that you're looking at but also the providers, the district health council etc. So I feel comfortable in saying there is dialogue. In terms of it being a specific type of approach, I think both of us are hesitating because we would have to—

Mr Jackson: It may not be as specific and as encouraging as it is in Thunder Bay, for example. You just don't know.

Mrs Goble: It may not have been posed in the way that you've posed the question.

The Acting Chair: Mr Wessenger, do you have a question?

Mr Wessenger: Yes. I'd like to thank you for your presentation and I'd just like you to elaborate somewhat on your comments on your governance, because you indicate that currently hospitals and homes for the aged are governed by boards of directors. Ultimately, they're responsible to the government and the community for overall fiscal integrity and managing the organization. Then you say you'd like to have this system of accountability applied to all long-term care institutions, and I'm just wondering how. Does that mean you would change the structure, for instance, of municipal homes for the aged, for one example, and second, what about the whole question of privately owned nursing homes? How would they fit into that?

Mrs Goble: In the CHO model, there is one governing body for the particular comprehensive health organization, and depending on its arrangement with its providers, some of those providers may well have a seat on the governing board of the CHO, but it is not our intent to disrupt the actual operation of any particular component within the CHO model. Whether they're a municipal home, an acute care hospital, a home for the aged, a nurs-

ing home or 25 of all the above, they would still have their operation. It's the agreement that they would come into the CHO where they would then either have a seat on the board or have representation through a collective seat on the board

Mr Wessenger: Maybe I'll just specifically make one recommendation about community advisory boards, or make a comment. Are you recommending that all institutions have community advisory boards?

Mrs Goble: We certainly see where that has been a sound way to have feedback from local communities and the actual consumers using facilities or organization services or outpatient services. We certainly see that this consumer input at each different local level has meant there is more influence in terms of the needs being responded to and the services being matched to the local needs.

Mr Wessenger: One further question: Do you think really that the CHO model is the best model for incorporating long-term care? Is that what you're saying?

Mrs Goble: The CHO model is the most comprehensive model. Any other model that is out there at the present time does not include all the elements. The CHO model does. It incorporates everything from the physicians, the acute care side, the nursing homes, the homes for the aged and the levels of care in the community. That's what it's all about. It is the comprehensive model. I think we would not be sitting here today if we did not believe it was the most comprehensive model.

Mr Murray: If I could just expand on that for one brief moment, the process has been going on for about five years now. When we started, the CHO model was an alternative that we were investigating, the idea of changing the way we delivered health care. Everybody was looking at it. It was an option, although everybody was quite happy with the status quo. The status quo is no longer acceptable. It's become imperative that we change the system.

I think at the time the long-term care reform-redirection was started several years ago, it looked to try to solve a problem with a specific part of the population. That same problem exists for the entire continuum of the population and the CHO model tries to address it in a more global sense. I guess the way we see it, what is being done with long-term care could just as easily have been done for the whole system and it would've been called a CHO.

The Acting Chair: Mrs Sullivan, you will complete the questioning.

Mrs Sullivan: My questions were quite similar really to those presented by the parliamentary assistant. My conclusion is that your recommendation is basically that the CHO should become a multiservice agency wherever possible. If that is not possible, is there not a conflict then between the work of the CHO in terms of purchasing services either in the community or in a facility and the work of the placement coordinator? How do you see that being resolved?

Mr Murray: I think the potential for a conflict is a great one. I think this is a situation where if a CHO is in place, it does have the funding authority flowed to it

through a number of health agencies. The whole reason for being of a CHO is local accountability, local decision-making, with a majority consumer-driven board. To me, it should have the say. That's my feeling. But there is the potential. That's why you need to work together. That's something the CHO, in our development stage, is getting quite good at. There's not a lot of providers who are coming to us with open arms. We seem to be a threat to the status quo. So we work with people instead of working against them.

Mrs Goble: If I may elaborate on Dave's response, I think too, in terms of the placement coordination situation, in the CHO model, given that you would have, for your members, all the components in place to support their needs, you would address and probably get around the issue of having to necessarily go before placement coordi-

nation. But having said that, that doesn't mean that you would not work within the community, because it might mean that within your CHO organization you could not support your member, and therefore you would have to use and work with placement coordination, depending how that was going to fall out in the future.

The Acting Chair: Thank you, Mr Murray and Mrs Goble, for coming and presenting again. I think you were making your point.

I would suggest then that the standing committee on social development adjourn until 10 am tomorrow morning in committee room 1.

The committee adjourned at 1730.



Substitutions present / Membres remplaçants présents:

Carter, Jenny (Peterborough ND) for Mr White
Hope, Randy R. (Chatham-Kent ND) for Mr Drainville
Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer
Jamison, Norm (Norfolk ND) for Mr Martin
O'Connor, Larry (Durham-York ND) for Mr Gary Wilson
Sullivan, Barbara (Halton Centre L) for Mr Daigeler
Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Con

Assemblée législative de l'Ontario

Deuxième intersession, 35e législature

Journal des débats (Hansard)

Mardi 9 mars 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Président : Charles Beer Greffier : Douglas Arnott

Chair: Charles Beer Clerk: Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 9 March 1993

The committee met at 1006 in committee room 1.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993

LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. We begin our Tuesday sitting of the standing committee on social development. We are here to deal with Bill 101, An Act to amend certain Acts concerning Long Term Care.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: Our first representation will be made by the representatives from OPSEU. If you would be good enough to come forward and make yourselves comfortable, welcome to the committee. If, first of all, you wouldn't mind just introducing yourselves for Hansard and for the members of the committee, then please go ahead. We have a copy of your submission.

Ms Jan Hibi-LeBlanc: Good morning. My name is Jan Hibi-LeBlanc and I'm on the executive of OPSEU's medical division. I'm also on its long-term care committee. I've been working at the Sudbury General Hospital for 18 years now, so I'm very familiar with the health care system.

I'll be doing a brief overview of OPSEU's position on long-term care. I have with me as well Phyllis Martin, who is a social worker employed at the Queen Street Mental Health Centre and who will talk about the work being done by her institution in the community. Tracey Mussett, who works in the home care program at the Renfrew County and District Health Unit will then talk about the impact of the long-term care proposals on women, families and their communities. Also with us today is Barb Linds, a research and education officer with OPSEU.

I have had copies of a brief distributed which contain much of the same material we shared during the public consultation process.

The Chair: Sorry to interrupt, but at the outset we will have the full half-hour, so you're conscious of that as well in case there is time for questions at the end.

Ms Hibi-LeBlanc: Okay. Sounds good.

The Ontario Public Service Employees Union welcomes the opportunity to make this presentation before the standing committee on social development. We have shared our views during the public consultation process and now wish to highlight our concerns before this committee. Long-term care is an issue that affects all of our members. Many care for the elderly and the chronically ill family members in our own homes and deal with a wide range of home care and support agencies; or we try to obtain the best care we can for family members in institutional settings.

Many of our members work in the long-term care sector: the acute and the chronic care hospitals, the psychiatric hospitals and community mental health agencies, homes for the aged, nursing homes, home care agencies and ambulance services, government-run facilities and community agencies that care for physically and developmentally disabled people and the government-run monitoring compliance and support operations.

Our members work as nurses, RNAs, ward clerks, lab technologists, cooks, housekeepers, ambulance officers, physiotherapists, social workers, counsellors and in all other professional and support capacities. For all of our members, long-term care is an important and emotional issue.

Reform of Ontario's system of long-term care services is long overdue. For too long, people in need of care and support have had to deal with waiting lists, inappropriate placements or had to do without because the needed service was not available. The system is fragmented, unplanned, uncoordinated, poorly regulated and out of touch with real needs.

OPSEU has put considerable thought into the question of what makes quality care. Our reform efforts are based on a number of important principles for the provision of care that people need and deserve:

- (1) Health care and human services should support independent living to the fullest extent possible and should emphasize health promotion and education and provide supports that give individuals control over their lives.
- (2) The system should support client choice. People who need care should have the right to determine, either individually or with their families, how care should be provided. To exercise this right, individuals should have an array of options to choose from.
- (3) Services should be provided on a continuum-of-care basis so that as a person's health status changes, the appropriate kinds of care, whether they be in a home or a facility, are provided in a coordinated and timely manner. Regardless of where they are provided, services should be integrated with community and family life.
- (4) Services should be provided in a culturally sensitive manner. Language, religion, food and other facets of culture must be respected.
- (5) Services should be of high quality and fully accessible. There should be comprehensive standards for care provided by institutions and community agencies. There should be monitoring and enforcement mechanisms to ensure maintenance of high standards of care.

- (6) Services should be fully funded and staffed to ensure accessibility and the maintenance of high quality standards
- (7) Vital health and human services should be provided only in non-profit, regulated settings.
- (8) Health care is society's responsibility. This responsibility must be fulfilled through government programs. Services must be delivered in a manner that makes sure that government is accountable to the public.

OPSEU has many concerns about government plans for the redirection of long-term care. We have concerns about this bill, to which we are asked to respond without having a full understanding of the government's overall policy directions.

The legislation before the committee today focuses on services for seniors and people with physical disabilities. It is an essentially technical bill which leaves huge gaps. It does not address the needs of children who require long-term care or people with dual diagnoses, for example, aging developmentally or physically disabled people or people who are elderly and also need mental health services.

Services for these people are wanting. Families of people with these diagnoses bear an enormous practical and emotional burden with little support from the health care system. The needs of these client groups and their families must be addressed in long-term care reform.

In addition to long-term care, the government is proceeding with parallel review and restructuring in the areas of acute care, chronic care, mental health care and care for people with developmental disabilities. There is considerable relation and overlap of these aspects of care, yet the processes of review and consultation are arbitrarily separated.

OPSEU would like to see a unified, rational health care system wherein there is a clear understanding of the roles and responsibilities of the various provider agencies. We are concerned that the review process will perpetuate the fragmentation.

The government is implementing changes to the longterm care services that are funded and provided despite the fact that the consultation process is not complete. The consultation process must include an examination of the roles and responsibilities of institutions and community agencies providing health and human services.

The government is scripting an increasingly limited role for institutions and laying the foundation for a potential explosion of agencies purporting to be community-based. There is little recognition by government that institutions are transforming themselves to be more responsive to needs within their communities.

Our society has invested in the institutional sector. It is wasteful to write it off as a narrowly circumscribed role. It makes more sense to transform the institutions to be made more accountable to the government and to the public, more representative of community interest. The range of programs they provide should be improved through careful planning and coordination.

Many hospitals, psychiatric hospitals and homes for the aged are already providing in-home, community-oriented services. They offer satellite and outpatient clinics, day

care, respite care, counselling, crisis intervention services and much more.

I'd now like to turn to Phyllis Martin, who will describe one institution-based model which works very successfully.

Ms Phyllis Martin: I'm Phyllis Martin and I work out of the Queen Street Mental Health Centre. I would like to give a brief overview of our program.

Long-term care reform focuses on the life choice of seniors and disabled persons to remain in their own homes while receiving the necessary community services. It also proposes easier access to community services and approved charitable homes for the aged through the placement coordination model. Many seniors, especially those who are cognitively impaired, are at risk in their own homes, and it is to the institution that they must turn for improved quality of life, social support as well as medical and psychiatric care. The institution cannot be divorced from the community. Institutions are vital components of communities, and communities play an integral role in the success or failure of institutions.

Queen Street Mental Health Centre is a large psychiatric hospital operated by the Ministry of Health which serves the areas of Peel, North York, York and Etobicoke. Queen Street Mental Health Centre provides a continuum of patient services: assessment, diagnosis, rehabilitation, discharge planning, housing and reintegration into the community.

There is a large psychogeriatric unit within the hospital that provides services for clients aged 65 and over with a psychiatric diagnosis. This unit has recently been described by the hospital accreditors as a model of excellence for the care of the elderly.

The psychogeriatric unit provides comprehensive, holistic and systemic services which begin with functional assessment, preferably in the client's home. This quality service continues possibly through admission and continues after discharge. Service is delivered by highly skilled professionals who have been using the placement coordination model effectively for the past 16 years.

There are three community-based satellite programs which provide follow-up care for clients who are discharged from inpatient status. Staff in the PACE, ie, psychological assessment consultation education, programs are actually involved with discharge planning since they are expected to provide follow-up care. PACE programs provide home assessment, psychiatric consultation and community assessment and provide educational services to nursing homes and homes for the aged on request. Admissions from retirement homes, nursing homes and the community have been reduced by 95% by the early intervention of the PACE programs. There are PACE brochures which will be left with the clerk.

Institutions are being transformed and will continue to be transformed by being more accountable and more accessible to the community and stakeholders. Institutionalbased professionals are involved in collaboration with community-based agencies in an effort to coordinate and identify services, thus avoiding duplication. 1020

There is fear among health care professionals that existing programs for the elderly will be replicated by the implementation of the long-term care reform. It is neither prudent nor judicious at this time to reinvent the wheel by creating a second level of bureaucracy, which will result in interruption of the existing service delivery.

The solution to this dilemma would be to provide funding in order to expand and update existing community programs. Funds should be administered through institutions and programs would focus on more equitable community care. Professionals providing similar services should continue to provide services in the new and expanded programs.

Professionals employed in provincial psychiatric hospitals have not been informed of the impact the long-term care reform will make to the existing programs. My question is, will provisions be made for the redeployment of personnel, or will positions be created taking into account the training and expertise of these service providers?

It is not incidental that provincial psychiatric hospitals were not included in the original submissions for long-term care reform. Area general hospitals are in the process of planning a coordinated placement service, again at the exclusion of the provincial psychiatric hospital.

Ms Hibi-LeBlanc: Tracey Mussett will now talk about what shifting the responsibility for the provision of long-term care into the community will mean to women as primary care givers and as workers.

Ms Tracey Mussett: Shifting the responsibility of costly health and social services to the community really means shifting the responsibility and those costs on to women. The family is presently the main source of informal care for our elders. The average age of an informal care giver in the home is 55 to 60 years old and 75% of those care givers are women. The formal care-giving network in the community is comprised primarily of women working in non-union jobs for which they are not adequately compensated.

Caring is an essential service. Care givers, those people who are now caring for our children and our parents and anyone else who needs help in our community, know that this is work that cannot be left undone. The needs don't stop at 5 o'clock, and these are needs that can't be met by just anyone. Personal care, housekeeping, meal preparation and laundry, just some of the physical things that are done in health care facilities, are now done by specially trained people who are paid for that important contribution. Why would we expect now that those needs can be met in the community by just anyone, either family, volunteers or workers in low-wage jobs, just because that's cheaper?

We cannot be certain what services will be required in the future. We need a comprehensive system of health, social and support services with flexibility and options that will meet client needs for home or institutionally based care and provide the needed support for family care givers. Formal care givers, properly trained and properly compensated, will provide the level of health care and the quality of life we expect our system to provide. Especially in isolated rural areas, where "home" is miles from another human being and family members are spread across the country, services have to fit, and fit very tightly. Cracks in this network have serious human consequences.

Ensuring that there is a full array of options in place before the shifting occurs is only common sense. We see what is happening with the continuing deinstitutionalization of psychiatric patients, as Saturday's Globe and Mail very graphically illustrated.

We need a clearer definition of what this proposal assumes is "community." Is it a single family dwelling on a paved street? Larger facilities are a part of our community, and they can feel more like home to somebody than a house or apartment. People do live alone, and their needs can be largely unmet. Community-based care does not necessarily have to be an ideal at the expense of the other institution-based care. Institution-based care does not have to be viewed as cold, grey-block buildings where horrible things are committed to people behind the walls.

We need a clearer definition of what this proposal assumes is "support to family care givers." Can they add another eight hours to a woman's day? Can they give back relationships lost, social and employment opportunities missed? Can they explain to a six-year-old child why his mother spends more time "playing" with grandma or the elderly person next door than she does with him?

Financial costs are just one of the prices paid by family care givers. Elder care is added to the ever-increasing and often conflicting roles women play as the concept of "family" evolves.

Safety is another very important concern. Care giving is a dangerous job. In facilities we have women who are exacting physical and emotional costs as a result of their labour. The pay equity process highlighted that emotional and physical demands of so-called "women's work" now have to be recognized in measuring job value. Care givers in the community share those dangers. As well we see women entering homes of strangers, often in isolated areas, where they will care for people with physical, social, emotional and psychological problems, and the safety issue is something that has to be addressed.

We believe that community-based services should be funded on the basis of parity with the institutional sector. Better wages would improve both the quality of care and the quality of work and family life for consumers and workers. The new system must recognize the important link between quality care and a stable, well-trained, reasonably paid work force.

The costs of care giving are very high. To save the system money, those costs are to be borne by care givers, formal and informal. But the capacity to care and to help is not a limitless and unconditional resource. We, as a community, must be very cautious about exploiting and exhausting the support we will continue to rely on.

While it had its rewards, my own personal experience with care giving exacted a very high personal price, and it is not an experience I highly recommend to working women.

This new system, a complex system of well-coordinated and carefully planned and comprehensive services and support, must first and foremost recognize that care is given by care givers. The system that works will respect, value, support and protect those who give of themselves to look after us all.

Ms Hibi-LeBlanc: Reform of the system of long-term care is critical and urgent. OPSEU has many concerns about the government's plans. We want to encourage the government to proceed carefully and ensure greater consultation and agreement about both the process and the content of the reforms. Thank you.

The Chair: Thank you very much for your presentation, which highlighted a number of different areas, as well as the brief you have presented. We do have some time for questions, and we'll move there right away. Mr O'Connor.

Mr Larry O'Connor (Durham-York): You raised a number of issues. In going through your brief, you pointed to some other areas as well. I found your presentation quite informative. As the parliamentary assistant to the Minister of Health, I did have an opportunity to go to Parkdale, to the community resource centre for survivor consumers, and found it really rewarding that this sort of resource is available to the people who have left Queen Street and that they were able to advocate for themselves and be together. I found it really exciting that there are possibilities coming up that perhaps weren't even thought about maybe 10 or 15 years ago.

You mention the need for training in facilities where the ex-psychiatric patients are. I know that does exist because my mother has worked in a long-term care facility, in a nursing home, with a lot of ex-psychiatric patients, and she had talked with me about some of the difficulties she had there. There is the need for that ongoing training so that there's something available for them. Those are really important concerns that you raised.

1030

Accountability is something I would like you to perhaps expand on, because what we've heard through this process of committee hearings is that there are residents' councils in nursing homes and they're in the municipal homes for the aged. Of course, the accountability mechanism comes through the municipal government.

I just wondered if you might have some suggestions as to what might be a good method of putting in some accountability that's going to really reflect the needs of the consumers we're trying to provide a continuum of care for that's really going to meet their needs. I hope you could maybe make some suggestions as to an avenue we should be looking at.

Ms Hibi-LeBlanc: I suppose one of the best methods would be a review system. Some of the homes for the aged that are privately owned we feel are not up to standard and there isn't anybody reviewing their processes and ensuring that the quality of care seniors or anybody with physical disabilities receive is standardized.

There is a standard set, I believe, by the governmentrun institutions, but the private institutions have no such standards, or a limited set of standards. If everyone was under the same umbrella and was required to meet the same standards, then we would probably see a system in place that would guarantee or at least assure a quality of care for seniors and disabled.

Mr O'Connor: What kind of mix would you suggest and maybe some sort of review panel or council? Who should be involved in that process?

Ms Mussett: Definitely clients and family care givers, the consumers, have to play a role in that. I was just going to add as well, presently where 90% of our elders are being cared for in the community, there is no standard of care to be provided by informal care givers at all. Elder abuse has been raised as a very real issue and care giver abuse also obviously exists. That's a very large segment of care giving right now that is not standardized at all, and if the shift is going to add to that, that emphasis on informal care giving system, then standards will even be harder to maintain. I think the consumers and the clients have to be involved.

Ms Barbara Linds: One of the other points we'd like to make is that there are existing institutions and programs that are accountable run by levels of government that should be expanded on and should form the hub of a health care system and not set up this other parallel system where there isn't the accountability that exists in the provincial and other levels of government—the care that's being provided by those facilities.

The Chair: I'm afraid we're going to have to move on. Ms Sullivan.

Mrs Barbara Sullivan (Halton Centre): I enjoyed your brief. Being a mother, I'm able to sort of read and listen at the same time, as we all know we can do with our children, but there are a couple of things I want to refer to from your brief as well.

Much of your brief, you will understand, our party will agree with profoundly and much of it we will disagree with profoundly, but I think it was very thoughtful and I think you will understand that for all members of the committee it's very difficult to deal with Bill 101 in isolation of the entire long-term care strategy. I think that's one of the things we're having a tough time dealing with.

The two things I want to ask about—and I think I will have to, on the first one, refer to the parliamentary assistant for a response—are with respect to maintaining standards in the nursing homes. You have indicated that your compliance advisers, who are members of OPSEU, have been told there will not be an increase in their complement when there will be a substantial increase in the number of long-term care facilities which will be brought into that system. Can the parliamentary assistant confirm that is the case?

Mr Paul Wessenger (Simcoe Centre): What I will confirm is that the existing compliance officers will, I understand, continue to monitor the present nursing homes with respect to homes for the aged. The existing program supervisors will continue to do the role they are presently doing. I will ask also for some addition by Mr Quirt.

Mr Geoff Quirt: Geoff Quirt, acting executive director of the long-term care division. It's accurate that the staff have been advised, and our plan is not to increase the number of compliance advisers currently working in the residential services branch. They will, however, work as a

team with a number of program supervisors who have traditionally related only to the homes for the aged program in each of the 14 offices of the long-term care division. While the staff of the residential services branch, the compliance advisers, will not be decentralized to the 14 offices, they will work as a team.

The people who used to work exclusively with nursing homes, the compliance advisers, will work with program supervisors who used to work exclusively with homes for the aged, as a team and relate to both nursing homes and homes for the aged. The resources of the 14 offices and the resources of the residential services branch will work as a team to monitor compliance with provincial standards in all types of long-term care facilities and also negotiate and sign service contracts with each facility annually.

Ms Linds: If I might make a comment on that, for the last week, I've been reading the transcripts of the presentations before the committee. I raised the question with one of our compliance advisers, which resulted in the comment that she made about the complement not being increased. I said that I understand that the program supervisors, the people who are now dealing with homes for the aged, are actually going to be doing work with some of these institutions and these facilities. She said that their skill sets are very different, that while they do programming and budgeting work, their skills are not the skills that are actually being used by the compliance advisers now.

My understanding is that the background of the compliance advisers is essentially nursing, and the program supervisors don't bring with them the same skill sets. So in fact if you're looking at the compliance area, it is just the same staff who are going to be doing the work with the extended system.

Mrs Sullivan: I think this is a matter of concern with respect to this particular bill because as we are looking for amendments and use of the word "inspector" or whatever, we may want to have more detail on how this totally integrated system is going to come about.

The other question I wanted to put to you is from page 11 of your brief, where as part of your argument about total quality management, which of course is something this committee is very interested in in terms of amendments to the bill, you've indicated that TQM has resulted in more injuries on the job and more stressful working conditions, has meant deskilling of work, has attempted to undermine negotiated work rule protection etc. What evidence do you have for that, and can you put additional information before the committee with respect to those statements made in your brief?

Ms Linds: This is work that we've done with people who are actually working in institutions. A lot of it is anecdotal. We can go back to the people we've talked to in our institutions and facilities to put together some more information on total quality management. Tracey has some comments.

Ms Mussett: I'm not a direct service provider; I'm support staff. As an example, in our organization, therapists have new patient quotas to meet. What that means in a county as large as Renfrew county, where 40 minutes of

that client's visit time is the therapist getting there in the car, is that when they have to admit four new patients a day, the quality of care has decreased. The kind of care has changed. TQM brings in an assembly line approach to caring for human beings that's just not appropriate.

Mrs Sullivan: That's interesting, because it's enthusiastically embraced not only in Canada but across all of North America and Britain. I don't know that we've had this kind of reaction

Ms Mussett: In manufacturing or in the allocation of health and social services? Is it being embraced in that field as well?

Mrs Sullivan: Yes, absolutely. Total quality improvement is in fact seen to be a multidisciplinary team effort to improve quality of care delivery to the patient, not as you are seeing it here, and so I was kind of interested in what you've included.

The Chair: I'm sorry; we're tight.

Ms Mussett: We'll have to have this discussion later, I guess.

The Chair: It is an interesting topic, but we have one more questioner and time is moving on. Mr Jackson.

1040

Mr Cameron Jackson (Burlington South): This is a very comprehensive brief and you've covered a lot of areas, which I appreciate. One of the areas though, having read through a section of it—I'd like to ask you a question, because I don't sort of see it highlighted or mentioned. Are you aware that the fundamental shift in Bill 101 is to take this from an insured service, guaranteed under the charter through the Canada Health Act, take it out of that and place it as a contractual service from the state? Are you aware that's the fundamental move that's implicit in Bill 101, so that it is no longer a guaranteed service to citizens for these services?

Ms Linds: We haven't looked specifically. We've looked at the bill. The problem we have with the bill generally is that none of it is being discussed in an overall policy context, so it's basically a piecemeal approach, and that's what we've titled our brief. You can't just look at one piece of the picture in isolation from everything else. The funding is just one aspect of it; the provision of placement coordination services in the community is another aspect of it. Our problem is with the whole policy direction and that it hasn't been enunciated to the extent that we can actually deal with any of it.

Mr Jackson: In all examples, enabling legislation enables the government to do whatever it wants. Then there are laws that restrict the government's ability to do certain things, such as compliance with the Canada Health Act. But given that the fundamental change on which everything else builds—to go in and say the state has the right to determine who is eligible now, and the state has the right to determine which facility you will go into and the state has the right to say you're not going to receive care in a certain fashion, and that people are going to pay, based on their ability to pay, in a variety of circumstances, user fees,

which aren't part of the Canada Health Act, as you know. That's the fundamental shift here.

I just wanted to make sure that your organization, a very important organization in terms of advocacy for these kinds of changes, is aware that this legislation moves fundamentally from the one system to another and that all the other enabling aspects of the legislation fall into place once they separate themselves from the universality of the Canada Health Act.

Ms Linds: We're very committed to universality and we're very committed to the state playing a meaningful, important role in the provision of human services. I don't think we have a question with that. What we have a problem with is Bill 101 in isolation from the total policy direction on long-term care.

The Chair: Thank you. I regret again having to play the heavy, but time has moved on. I know I speak for all the members of committee in thanking you for both the manner of your presentation and the different backgrounds of the people whom you've brought. That's been very helpful.

If I might, just as one who has been in a number of the institutions over the years, in response to one comment that was made, it always struck me that the quality of the people who worked in all our institutions is extremely high. I think, whatever the discussion is around institutions and community care, nobody should be surprised to learn that we have some very fine people working in all of our institutions, and for that we thank you.

May I call the next witness and then we'll go on with the representatives from the Christian Labour Association of Canada. Ms Sullivan.

Mrs Sullivan: Mr Chairman, I was wondering, as the next presenters are coming to the microphones, if legal counsel to the ministry could provide a response to the issues that have been raised about the delisting of services under medicare and the Canada Health Act implications.

The Chair: Okay. Yes, parliamentary assistant.

Mr Wessenger: I'd just like to make a statement with respect to this issue that's been raised by Mr Jackson. Extended care services provided in nursing homes are currently included as insured services under the Health Insurance Act. This will no longer be the case when Bill 101 is passed. Only Ontario and Manitoba currently insure extended care under provincial health insurance plans. Extended care services are not required by the Canada Health Act to be insured, nor are they subject to the requirements of public administration, comprehensiveness, universality, portability and accessibility, nor is there any constitutional requirement that a province provide or insure extended care services.

Interjection.

Mr Wessenger: Yes.

The Chair: The answer to that was yes, just so that it's clear.

CHRISTIAN LABOUR ASSOCIATION OF CANADA

The Chair: I want to welcome you both to the committee this morning. If you'd be good enough to introduce yourselves for Hansard and for the members of the committee, then please go ahead with your presentation.

Mr Ray Pennings: Thank you very much. My name is Ray Pennings. I'm a national representative with the Christian Labour Association of Canada. With me is Betty Westrik, one of our Ontario representatives who's active representing workers in the health care industry.

We'd like to thank the committee for providing this opportunity to give input on this important piece of legislation. Our interest and involvement in the issues surrounding the provision of long-term care have been well documented, as we've been actively lobbying to address the inadequacies of our current system since the fall of 1984.

Our vigilance and concern about these issues originates with the 3,500 CLAC members who are employed in 67 different nursing and rest homes, charitable and homes for the aged throughout this province. These members work on the front lines and are committed to providing quality care for our seniors. The concerns of our members are not just about working conditions and job security. It's a genuine commitment to the residents whom they serve and care for on a day-to-day basis.

In October 1985, we released a comprehensive task force under the title Serving our Seniors and again, in October 1990, under the title Living in the Twilight. These reports examined the conditions in Ontario's long-term care facilities and made specific recommendations for improvement. Extensive coverage in both electronic and print media helped raise both public and political awareness regarding the issues concerning long-term care.

In 1987 we appeared before this committee to comment on Bill 176, but we continued to press for an overall review of the system. That overhaul is finally happening, and while we regret the slowness with which the wheels of government seem to turn, we are thankful that we can appear today to provide input at this final stage of this process.

Just as a parenthetical remark, our comments are focused on Bill 101. We obviously have opinions and comments on the larger trends in long-term care reform, but we have reserved our comments to specific amendments to Bill 101 at our appearance this morning. However, in discussion we'd be happy to pick up whatever areas you want.

We're here this morning to voice our support for the legislation, to urge its speedy passage so that the concerns of those in the long-term industry can be dealt with instead of just talked about. Still, there are a few specific concerns with the legislation that deserve comment and we think the committee will do well to propose amendments to address the weaknesses in at least three areas.

The first area of concern is that of service agreements. We fully support the introduction of service agreements as requirements in order to receive funding for long-term care in this province. We also understand the limitations placed on the province in dealing with a municipality which is providing long-term care as the fulfilment of its statutory responsibilities. The fact remains, however, that the municipal

homes for the aged, by not being required to sign service agreements, will continue to receive different treatment from the ministry than privately owned nursing homes. In our view, that's unacceptable. Our members are employed in both private nursing homes and municipally owned homes for the aged, and from both a patient and care perspective these two types of institutions are providing essentially the same service to Ontarians.

For many years, the gross funding inequity between privately and municipally operated institutions has created staffing hardships for our members in nursing homes. We are thankful to see a single funding formula put in place for both by this legislation. But we fear that by requiring the one to sign service agreements and not the other, the difference in treatment between public and private long-term care facilities will continue.

When we hear whispers and rumours that there's a covert agenda to eliminate the private component of the long-term care program and replace it with entirely publicly owned and operated facilities, then it's understandable that these differences, like the ones specified in regard to the service agreements, arouse suspicions of a larger agenda. This remains so even if the different treatment is defended with legal distinctions.

We would recommend that the committee look at this matter carefully so as to ensure that municipal homes for the aged are placed under the same requirements and commitments in order to receive their funding, and that this legal technicality is not used by the ministry to effectively disadvantage private nursing homes, their staff and residents in relation to their public counterparts.

Long-term care is about people: the residents and the staff of the institutions responsible for caring for them. Long-term care is not about preferences and mindsets concerning public and/or private ownership of such institutions. The urgency for reform and the scarcity of our resources is too great to allow ourselves to be diverted from getting on with the reforms in the best way we know how.

1050

While we realize that the contents of the service agreement will be determined by regulations, we would also urge that the present minimum hands-on, direct personal care requirement of 2.25 hours of care per resident per day be incorporated into the service agreement. Although the accommodation, care, services, programs and goods required under the service agreement will be communicated to all residents and the funding envelopes will provide direct subsidy for staffing costs, there is not adequate provision to ensure that the money is spent on hands-on personal care.

It is easy to envision how management will seek to direct the resources, which remain limited and scarce, to some of the more visible areas of service at the expense of the personal care of residents. Providing staff with a manageable rather than overloaded daily assignment of residents will give them the opportunity to pay attention to the residents' personal needs and provide for greater personal interaction. These opportunities are currently and sadly lacking, and that must be addressed if we are at all serious about the human beings, our relatives, friends and neighbours, to whom these institutions are providing full care.

The provision of human contact and personal relationships between residents and staff may not be as visible and objectively measurable as the newly created positions of activation coordinators and the like, yet it remains the most effective and necessary component of any standard of quality care for our seniors. Such interpersonal relationships cannot be legislated; however, they can be encouraged by tying specific minimum staffing requirements of not lower than 2.25 hours of care per resident per day to the case mix index, thereby obligating operators to staff adequately in order for this interaction to occur and, it goes without saying, obviously funding accordingly to allow this to occur as well.

The second area of concern is that of the placement coordinators. When the 1991 public consultation paper was released, we strongly endorsed the commitment to "the primacy of the individual and his or her right to dignity, security and self-determination." However, we're concerned that the powers entrusted to the placement coordinators in this legislation do not adequately provide choice and flexibility for residents.

It is intended, and rightfully so, that placement coordinators will merely apply the eligibility criteria set out in the regulations and prioritize an applicant's need in relation to available space, but as matters stand, we see a great potential for placement decisions that will not be reached in as objective a manner as they should be.

Ultimately, these decisions will have a considerable degree of subjectivity. What methods of accountability are put in place for the placement coordinators? How will the system deal with the inevitable public versus private bias that coordinators may have? What about favouritism by the coordinator towards a particular home?

When one considers the immunity protection provided for placement coordinators within the act, there seems to be a tremendous degree of trust in a single position, with very little accountability. The legislation should give a framework within which there is opportunity for input and choice for the applicant as well as accountability on the part of the coordinator arranging the placement.

Under this legislation, we suggest that the position of placement coordinator is given an undue degree of control without appropriate checks and balances. If this is left unamended, there is a real potential for abuse by those put in this position. The structure does not provide adequate remedies to address this without potentially causing injustice to residents, employees and particular institutions.

The third area is funding. The replacement of the twotiered funding system currently in practice with a single formula based on the needs of residents is most welcome and long overdue. We also recognize that the fiscal realities facing governments at all levels make increased funding for any program or area difficult.

Given that, we find it difficult to accept that long-term care residents are being asked to bear an undue proportion of the fiscal restraint burden. While we have made major advances in implementing a case mix index to determine the distribution of funds, the government determines beforehand how many dollars its going to spend. Thus, funding is not being based on the care needs of institutional residents,

and the delays in the introduction and passage of this legislation, without interim funding provisions, have resulted in many residents having to cope with declining care and many nursing homes facing perilous financial situations.

The summary of form 7s published by the Ministry of Health shows operating losses throughout the industry during the past several fiscal years and, since January 1, in almost every private nursing home we have dealt with, reduction of staff, which translates into a reduction of care. Obviously, this causes unfair stress on our members, who are concerned about their patients, and it creates near-impossible situations for our union in negotiating on behalf of workers in an industry that historically has been underpaid when compared with other institutions and hospitals providing the same sort of care.

In conclusion, our critical comments and observations should not be interpreted as disapproval of the legislation. In fact, we support Bill 101 and think it's long overdue. We trust that our constructive criticism has alerted you to some of the bill's weaknesses and that our suggestions will contribute to a long-term care delivery system that will result in a welcome improvement of the quality of life for all Ontarians.

We owe it to our elderly to care for them with dignity, supported by a plan of care, inspection procedures, a fair funding mechanism and other necessary improvements. The government is to be commended for taking on this difficult task.

We recognize that no system will be perfect. However, we do believe this bill can be improved upon, especially as it concerns the service agreements and the role of placement coordinators, as we've outlined earlier in this submission.

Finally, we wish to impress on you the need to deal with this legislation and necessary amendments quickly so that the new funding mechanism can be put in place and the uncertainty which currently lingers over the industry can be lifted.

We thank you for your time and look forward to answering your questions.

The Chair: Thank you very much for your presentation. We'll move right to questions. Ms Sullivan.

Mrs Sullivan: Thank you. This has been a useful brief and we appreciate having it.

One of the things you have raised is the different treatment of municipal homes for the aged as compared to charitable homes and nursing homes. I wonder if we could have a clarification from the parliamentary assistant with respect to the signing of service agreements by municipal homes. I note that in Bill 101 there isn't mention of a service agreement with a municipality until we get to subsection 18(9), where it speaks about a contravention of a service agreement, and I think there is confusion here.

Mr Wessenger: I'll be very happy to clarify that. Under the amendment to the Homes for the Aged and Rest Homes Act—I'd refer you to subsection 28(2)—it says, "No payment shall be made under subsection (1) unless the municipality, each of the municipalities or the board of management, as the case may be, receiving the payment is a party to a service agreement with the crown in right of

Ontario." So in fact it is right in the legislation that the municipal homes for the aged, in order to receive their funding, have to be parties to the service agreement.

Mrs Sullivan: Thank you. I wanted that clarification, because such a significant part of the brief was with respect to different treatment within a system, when in fact we are looking at equalization of service and equalization of treatment between the homes.

Mr Wessenger: Could I just add one aspect? It's not a condition of operating a facility, as it is in the case of a nursing home, because there's a mandatory requirement that municipalities do operate homes for the aged. So there's that difference. But as far as the requirement of funding and service agreement are concerned, they're the same.

Mr Pennings: So what you're saying is that the service agreement for municipalities puts the same onus on them as it does on the private nursing homes, in terms of funding being tied to the delivery of care?

Mr Wessenger: That is correct, yes.

Mrs Sullivan: It's just a different signatory. One of the things we've been interested in with charitable homes, by example, is who is going to sign the service agreement and how that will be dealt with in terms of the accountability of the board of directors. The municipality is clearly on the line for services that are delivered through the homes for the aged.

The Chair: Mr Wilson.

Mr Jim Wilson (Simcoe West): Thank you for your presentation. I'm a little confused, because you state that you want this legislation passed expeditiously and that you're supportive of it, yet you brought forward some major concerns which are going to take some major amending, and I'm not sure how much give and take the government's going to show on this legislation. If other pieces of health care legislation that we've been through are any indication, it's a difficult task to have amendments accepted.

1100

I want to talk about funding. You mentioned interim funding. I think that one of the political games that's been played and that a lot of groups have bought into is, "You can't have the funding that was promised"—by Frances Lankin—"unless this legislation is passed." It's a carrotand-stick approach.

I don't believe that's true. The government could flow the funding if it had the dollars, particularly because there is money outstanding to nursing homes and the nursing home sector. That's something the government has sort of crept into these hearings. As we've gone along, it's become sort of a gun to the head of Mr Jackson and me, that we've got to pass this legislation, even though we have major, major problems with it.

One problem Mr Jackson was talking about before is that this legislation flies in direct contradiction to anything Frances Lankin told us when she was minister, and I've been her critic; that is, that she wasn't going to delist any OHIP medicare services without full public consultation, and that's certainly not been the case with this. We're on a

dangerous slippery slope here, and I'm surprised that groups such as yourselves would be so supportive of this legislation.

Ms Betty Westrik: Maybe I can answer that question. The government did involve us in a lot of these consultations before, with the service agreements and the funding etc, and it promised that whether the legislation was in place or not, funding would be forthcoming on January 1.

Mr Jim Wilson: Exactly. But the game's changed, hasn't it?

Ms Westrik: The game has changed. That's our concern, and that's why we're asking for interim funding. If we have to wait now until this legislation is passed, because it wasn't introduced until after we had already been promised the funding, then I guess we wouldn't be sitting here today and asking you to expedite this as quickly as possible.

Mr Jim Wilson: To be fair, I do very much appreciate your comments, as OPSEU said before. As legislators, I very much resent having to pass this legislation because we know the sectors need the funding. We're left in a void, as are the groups themselves and service providers, in terms of what the bigger picture is.

Ms Westrik: Maybe I can just state something else, because I do work out in the field all the time. I've been spending most of my time, instead of preparing briefs etc, going out there and dealing with staff cuts. Even though all these nursing homes have signed agreements that they're going to staff at 2.25 and the per diem funding was there for that, they're cutting right down to 2.2 or 2.15. So they're in violation of their service agreements and the government is doing nothing about that. That's a real concern.

Mr Jim Wilson: I agree, and I appreciate you raising that. I just finished a tour in London, Ontario, and I've certainly been to all the ones in my own region, and that's exactly what's happening. It's frustrating, I'm sure, for you, as it is for us, in that what we're seeing in the real world does not at all match all the great speeches surrounding this legislation. I appreciate your comments.

Mr Wessenger: Thank you very much for your brief. I'd like to make a comment on your questions concerning the accountability of placement coordinators. I think first of all we should remember that the placement coordinators are subject to a community board, so they do have that accountability in the sense that the community board manages the placement—

Mr Jim Wilson: Would the parliamentary assistant please speak up?

Mr Wessenger: That's unusual. Usually people say I speak too loudly.

Mr Jim Wilson: You're getting to be like Mr Peterson. When he used to get in trouble, he would mumble away.

Mrs Sullivan: You weren't here then.

Mr Jim Wilson: I was here then. I was an assistant.

Mr Wessenger: I was just going to indicate that placement coordination is run by agencies which have commu-

nity boards, so to that extent you do have accountability, but I do take into account your comments that you think there should be additional accountability placed on the placement coordinator.

Mr Pennings: If I can expand a bit on the environment, in preparing this brief we sought to focus very specifically on Bill 101 and a few immediate things. In other forums we have been very vocal in terms of the funding arrangement, and also in terms of the issue you raised about the coordinators. I guess sometimes what is said in public and what appears nicely in documents is quite different from what one hears day to day in walking in and out, as we do, of 67 different facilities in which we represent members. We have a good number of private nursing homes where we do represent members, and there is reason to believe, based on whispers and rumours-I can't pull documents out to suggest things—that there is a larger agenda this whole thing is part of to bring private nursing homes entirely out of the system and to replace that. That I guess is a little bit of a concern. If that's the agenda of the government, let's put it up front and let's deal with it and make that part of the legislation. If it's not, let's not play the games, as seems to be happening.

The concern is there. It's heard in a number of ways. I guess when we see the placement coordinators given the sort of latitude they are without systems of accountability, you can understand that the red flags go up and we say, "Wait a minute, is this another mechanism and part of a covert agenda?

The Chair: Final comment.

Mr Wessenger: If I might just respond to that, certainly we wouldn't be bringing in level-of-care funding if there was any agenda other than to provide a level of care that's the same in both institutions. Certainly, the intention is to bring up the level of care, to equalize, whether a person is in a private facility or in a non-profit facility. I'd like to assure you that is the intent of the legislation.

Just as a comment, we keep hearing all the time about the fact that there's a waiting list for long-term care facilities. I don't see why anyone would have any fear that there would be any withholding of a placement other than on the basis of a facility being in extreme noncompliance with regulations. Certainly, we have a major concern that the institutions are accountable and we want to ensure that the legislation ensures they are accountable in that regard.

The other thing is, as you may know, this bill was introduced in November. With respect to the situation, there have been two prior interim bridge fundings granted to the nursing homes. Certainly, we want to see this legislation introduced as quickly as possible.

Ms Westrik: Wait a minute, did I hear you say there's been bridge funding since November?

Mr Wessenger: No, I was saying there'd been bridge funding last year.

Ms Westrik: It was January and April of last year,

but that wasn't bridge funding; that was tied directly to staffing. It was tied directly to staffing, it wasn't bridge funding, which is why they're now in violation of their service agreements in order to make ends meet. **Mrs Sullivan:** Exactly. You left them in a cash flow crisis because you didn't flow the funds at the appropriate time. There were three or four months when there were no funds flowed

Mr Wessenger: I will ask for clarification from Mr Ouirt on that matter.

The Chair: Mr Quirt, briefly please.

Mr Quirt: As Mr Wessenger mentioned, there have been two bridge funding initiatives to date. There was one that increased the funding for nursing homes and charitable homes for the aged, September 1, 1991. It did carry with it a requirement that nursing homes move halfway to the standard target of 2.25 hours of nursing and personal care per resident per day and move completely to 2.25 hours by April 1, 1992. At that point, an additional \$1.32 was added to their per diem with no additional requirement for increased staffing.

You're quite right, the first bridge funding initiative required that all nursing homes come up to a minimum standard.

Some of the homes were above that standard and did not have to add any staff. Others were below it and had to achieve that consistent 2.25 hours.

The second bridge funding initiative did not require any additional staff time to be delivered on the part of the nursing home. That bridge funding initiative benefited both private sector nursing homes and charitable homes for the aged, which stand to benefit the most from moving to a level-of-care funding formula.

The Chair: If you have one last comment, that's fine, but I'm afraid we're going to have to move on.

Mr Pennings: I guess the point we would want to make is the fact that the commitment was clear that on January 1 of this year there was going to be funding in place. It was supposedly in place with this past legislation. That's not happened, nor has bridge funding. In the meantime our members are sitting there holding the bag, and frankly, we think that's grossly unfair.

The Chair: I think your point is clear.

Ms Westrik: The other point is—just in a comment to Mr Quirt—when was the funding finally channelled through to the nursing homes that was promised on January 1 and April 1? We were already in a serious problem last year, but because of the fact that long-term care was going to become a reality, everyone felt they could live with it and tried to work as expeditiously as possible towards getting it into place. Long-term care was already in place under the Liberal government. This was three or four years ago, and we're still talking about it. So in light of that, I still think we have a very serious financial problem out there. Like I said, that's why the violations are there.

1110

The Chair: Thank you both very much for coming and for making your presentation this morning.

I'd now like to invite the representatives from the York Region District Health Council to come forward, please.

Mrs Sullivan: Mr Chair, as the next presenters are coming to the platform, I wonder if we could have a written

document from the parliamentary assistant that describes in detail the flow of funding to nursing homes on the basis of the new nursing care requirements. I recall, by example, raising a question in the House when it took the minister by surprise that in fact the money had not flowed for some months. The House was advised by the minister that there was a problem with the computers.

It seems to me that the minister and her officials knew when the funding was to flow, when the additional funding was to flow. There was a gap of several months. The funding was not made retroactive in a manner that covered any interest charges, so that the nursing homes were left in a position where the carrying costs of the funding that was not provided on time were left to the nursing homes. That has contributed to part of their cash flow problem.

Mr Jim Wilson: They're particularly worried now that Floyd's selling computers.

The Chair: The parliamentary assistant will provide that information as requested.

Interjections.

YORK REGION DISTRICT HEALTH COUNCIL

The Chair: Order, please. Members of the committee, we do have guests before us this morning. The Chair in particular wants to welcome the next witnesses, coming as they do from York region. Also, I think, if I'm not mistaken, that this is the first presentation before the social development committee. I believe that if you are not the youngest district health council, you are very close to it. I know I speak as well for Mr O'Connor in welcoming you to the committee. If you'd be good enough just to introduce yourselves, then please go ahead with your presentation.

Mr John Rogers: Thank you, Mr Chair. My name is John Rogers. I'm the chair of the York Region District Health Council. I thought you were going to tell us that we were the youngest-looking or the youngest members of a district health council in Ontario. Unfortunately, that can't be the case.

Mr Chair, I'd like to introduce to you Graham Constantine, our executive director. Graham has been with us for a relatively short period of time; he was brought on in December 1992. John Wilson is a member of the district health council. John will be making the presentation on behalf of York Region District Health Council.

Mr John Wilson: Creating a new direction for delivering human service is a major challenge, and the province is to be commended for its efforts to reform long-term care. The newly formed York Region District Health Council is currently gearing up its long-term care planning capabilities in order to play its part in reform.

The York Region District Health Council has only been in existence since June 1992 and has only had staff in place since late in 1992. Nevertheless, the council feels obligated to bring concerns from the region forward to the standing committee for consideration.

By way of background, I'm sure you're all aware that York region is the fastest-growing region in Canada, its population having doubled between 1981 and 1991. The region has a current population of 530,000 and covers an

area of 425,000 acres. The vast majority of the inhabitants of York region reside in the southern part, while the northern part of the region remains largely rural. Just over 7% of the current population are 65 years of age or older, and an estimated 18% of the total population have one or more disabilities. The number of persons aged 80 years and older is expected to triple in the next 20 years.

Prior to the existence of the York Region District Health Council, the provincial government's long-term care area office and the Simcoe County District Health Council undertook an extensive community consultation process. The process resulted in 5,500 people participating in 261 consultation meetings held in neighbourhoods, people's homes, community centres, hospitals, churches, nursing homes and homes for the aged. In addition, 1,000 people also provided input through 600 individual and family feedback formats sent out through community agencies, 106 interviews with individuals, 96 briefs and letters, and 181 feedback phone calls and walk-ins.

As a result of this consultation, York-Simcoe presented over 300 reports and submissions to the government of Ontario provincial response centre, contributing advice to the Minister of Health, the Minister of Community and Social Services, and the Minister of Citizenship with responsibility for human rights, disabled persons, senior citizens and race relations, for incorporation into the policy decisions on the redirection of long-term care.

Through the consultation, the people in York-Simcoe indicated that they wanted to be independent and to make choices within a framework that ensures a community safety net of support services. They wanted short- and long-term care to be available when it was needed and they wanted these supports to assist them to maintain their dignity and enrich their lives.

Our purpose in bringing forward this brief today is to identify a number of common themes in this detailed and far-reaching consultation which do not appear to have been addressed adequately in Bill 101. We recognize that a number of other organizations have expressed similar concerns. However, our perspective is that the provincial government published its redirection paper in October 1991 and a great deal of effort and enthusiasm went into providing the opportunity for broad-based community consultation.

In undertaking this exercise, expectations have been raised that have not been realized in Bill 101. It is our view that in soliciting these comments on the document, the provincial government not then ignore the concerns raised. Our specific concerns revolve around the theme of "The reformed long-term care system must promote consumer independence, control and advocacy" in the consultation report.

Under Bill 101, as currently published, it would appear that consumers will be compelled to accept placement in a facility even if they do not believe it is in their best interests. Similarly, facilities are concerned that they will be forced to take residents that the facility is not capable of serving appropriately or whose placement will not be in the best interests of other residents or the individual.

Currently, despite the inadequacies of the long-term care service system, seniors face few obstacles in choosing the care and/or services which best suit their preferences and resources. Our concern is that Bill 101 is silent on the matter of consumer choice and appears to limit or eliminate the choices available to seniors. Similarly, we do not feel that the bill, in its current form, addresses the needs of elderly couples. From a compassionate standpoint, we feel there must be assurances that would permit couples to stay together in the same facility even though their individual needs may be different.

While we have heard assurances from government representatives that consumer wishes will be respected, we urge that these assurances be made explicit in the statute either in a preamble or, preferably, in the sections dealing with the issue.

Consumers, we've been told, also want a commitment to the concept of a full continuum of care within local communities. Consumers often choose to live in a given community because they consider that community to be their home. While they may, for reasons of health, come to need a variety of support services or even institutional care at some point, they do not want to be forced to leave the community they consider to be their home.

Consumers presently residing in facilities are also very concerned that they could be moved back to the community against their wishes. Consumers and their families are worried that the services they will require will not be available in the community and that individuals might be at risk. The bill, as currently formulated, does not seem to ensure that the applicants choices and preferences must be considered by the placement coordinator.

Against the background of the consultation process, the themes identified with regard to patients choice and continuity of care do not seem to be adequately addressed or explicated in Bill 101. We respectfully request that these issues be more fully developed through this standing committee.

The Chair: Thank you. We'll begin the questioning with Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. I think it was succinct and to the point.

I would agree that much of what we heard in the public consultations isn't reflected in the bill. If I can, without being too patronizing, I particularly want to congratulate your region, along with my county, Simcoe county. Jack is to receive a great deal of credit. The public consultations that did take place were really quite impressive, and I was very pleased to see the extent of participation.

1120

I did hear, as you mentioned in your brief—and it's the first time I've seen it; I've raised this and committee members are getting tired of the story. I remember one of the public consultations at Simcoe Manor in Beeton, where a couple of residents said to me afterwards—they didn't want to say it publicly—"Does this mean we have to go back to the farm?"

You mention that in the line here where you say, "Consumers presently residing in facilities are also very concerned that they could be moved back to the community against their wishes." This is the first time somebody's

finally told the truth on that one, because there was a worry out there and how well-founded that is as a subject for debate

I want to ask you about consumer choice and about facility choice, because I don't think you really touched on that, but we've heard a lot about it. Have you had the opportunity to make specific recommendations to the government with respect to this prior to today and, if so, what has the response been? You mentioned to the committee that perhaps we should do this in the preamble of the bill. I note that Dave Cooke, when he was in opposition, managed to get a preamble put into the Nursing Homes Act, which talks about consumers' choice in its attributive clause, which talks about respecting religious, cultural and linguistic characteristics. I just want you to comment on that.

Mr Rogers: Perhaps I'll let John give a more detailed answer, but I would like to emphasize that because we're such a new district health council we are just in the process of forming our long-term care subcommittee of council and therefore we haven't until today had an opportunity to come forward with recommendations with respect to this particular bill. I know John would like to comment on a couple of the points you've made.

Mr John Wilson: Yes. To address the question you've put, I'd make an observation on what appears to be the case when seniors are looking at their future and planning for their future. Very often what they attempt to do is to marshal all the options they have at their disposal and try and create a predictable future over which they have some measure of control. Part of the concern we see here is that at the point where the individual may need to go into a care facility of some kind, there seems to be a complete severance of that control and it appears that at that point, all of a sudden, they're going to simply have to go wherever they happen to be sent.

My observation is that the issue of predictability of the future for seniors, particularly as they see their health failing, is extremely important. We hear this again and again: "We want to know where we're going to be in five years. We want to see that there is a clear care stream we can follow and that whatever happens we know where we're going to be; we don't simply know that in five years there will be a hearing of some kind and we'll be sent somewhere."

Mr Jim Wilson: Along the area of placement coordination, we started off in the public discussion paper on redirection talking about 40 service coordination agencies—I think I still have the term right—and now we have this placement coordination layer that's going in. It does exist in some areas, but it certainly doesn't exist in others. Are we any farther ahead or are we somewhat behind?

You talked about raising expectations. When I sat through some of those public meetings, I was very worried that we were raising expectations beyond any government's ability to deliver, and it never once crossed my mind that there would be this sort of draconian placement coordination system this bill envisions. It's Big Brother at its worst as far as I can tell. The government will tell you its intentions are different, but you can't take

those to the bank, so we will try and introduce amendments. Are we any farther ahead, do you think?

Mr John Wilson: I think from our standpoint we'll probably need to see the next set of policy announcements to get a real sense of how it's intended this will be worked out in practical terms. At the moment we've really got relatively little information on the change that's anticipated from the old service coordination agency to what's to follow.

Mr Jim Wilson: Okay, that's fair.

Mr O'Connor: I want to again reiterate what Mr Beer says. Though members of the Legislature from York region may disagree on a number of things, one thing we were quite overjoyed about was the fact that we finally got the district health council up and running. In fact your presentation here today shows a commitment that you're going to be an active one. I hope we can meet on a regular basis. When you feel that a piece of legislation is directly going to affect the community you represent, we'd like to hear from you, and perhaps even more often.

I know that the chair of the DHC will realize, as a lawyer, that sometimes in legislation the intentions that are meant to be put into the legislation don't always get put into a language that the lawyers seem to like to put things into. In the consultation paper that went out—and you've talked about it in your brief, the renewed vision and the primacy of the individual rights for dignity, security and self-determination. Some of that doesn't show up in the legislation. I don't know how we can challenge lawyers to perhaps make legislation a little bit more human. I guess that's a challenge we can throw out to them.

Knowing that York region is new, in fact last night had a meeting that was facilitated by the district health council to talk to people about the long-term care subcommittee and how the role of the DHC is going to fit in there, the question—just maybe going along the same lines as Mr Wilson's phrase—was somebody from the placement coordination service, which is provided, I do believe, by the VON in York region now, there last night?

Did you feel that during the conversation that did take place there could be a problem there? Because I know that as we're looking at this legislation we want to try to make sure we're keeping everything in mind. Perhaps you can bring us something quite fresh that we haven't even had a chance to hear in this committee, as you had the meeting just last night.

Mr Rogers: At the meeting last night actually I don't think there was a specific representative from VON who certainly identified himself or herself as being from VON. I have a meeting, along with Mr Constantine, with VON in a couple of weeks' time and that is going to be one of the topics of conversation, I'm sure, at that time.

Again, the purpose of the meeting last night was really to hear from Mr Harmer about the long-term care reform process in York and to establish how our committee would be structured in order to take into account all the various concerns raised in the community. At this point I wouldn't want to say we had a discussion last night about it, but I think from the results of the discussion on the makeup of

the committee we will be having those types of discussions. We will have the opportunity to discuss it with both VON and any other persons who are interested in that specific aspect of long-term care reform.

Mr O'Connor: You've mentioned right in your brief the vast size of York region, that you do take into account the rural areas. There are a substantial number of longterm care facilities in the outlying areas that should be represented so that we have people from those communities involved as well. I'm sure you will take that into consideration

Mr Rogers: Yes, that was a very clear aspect of the decision, that the geographic representation of the region would have to be fully represented on that subcommittee.

Mr O'Connor: Thank you very much. Thank you for appearing.

The Chair: Thank you. I'm going to briefly lift my hat as Chair and, just as a member from York region as well, explore a couple of things I think that both Mr Wilson and Mr O'Connor have done, partly around the emerging role of the district health council in long-term care, but particularly because during the last few years in York region the regional government has been indicating a greater interest in the area of health and social services.

I wonder, in the thinking that you have been able to do to date, and I quite understand that you're at the beginning of this process, how do you see that link between the district health council and its responsibilities as put forward by the Ministry of Health and the responsibilities of regional government in developing the long-term care system for the region?

We'll let the former mayor answer that one. We can't just accuse you of being a lawyer.

1130

Mr Rogers: Exactly. I'm being painted with all the worst sides on that list of items that people admire in people.

The Chair: If I might, for anyone reading Hansard, as the chair of the district health council, you were the former mayor of Georgina for a number of years. But I just think, as you're going to answer this, that this is one of the critical issues as we go forward, who is playing which role and how we see that working out.

Mr Rogers: I think it would probably be appropriate at some point to meet not only with us but with representatives from the region of York.

The Chair: They're here tomorrow.

Mr Rogers: You should have had them today. The region of York staff and ourselves have had a number of meetings, and we're just in the process now of trying to establish a good working relationship with region of York staff. It's centred not only on issues such as long-term care but on other issues as well.

I think we need, as a DHC, to take a much more prominent role in the issues of long-term care and long-term care reform, and I certainly see that as the role government is currently asking DHCs to play. We need to be able to work in close conjunction with the regional municipalities and

any other agencies that are in the area to ensure that the direction is an appropriate direction that will look to the needs of the people we're serving, not to look to the needs of the DHC, the provincial government or the regional government.

We're there, in my mind, to ensure that the grass-roots organizations are listened to; that in the facilitation of the process of long-term care reform, the region is responding to those needs; that we work as honest brokers, a term you may have already heard a lot of DHCs using; that we are able to facilitate the process and make sure that the views of both the region and the province are known; that we can see how those all function together, again emphasizing the fact that the residents, the people we serve, are the people who are going to come out in the end as being properly served.

The Chair: If I recall correctly, there are three representatives from regional council who sit on—

Mr Rogers: Four representatives.

The Chair: Okay. Thank you. Mr Wessenger had a point of clarification.

Mr Wessenger: I just note your statement about consumers being concerned about being moved from a facility and I'd like to assure you that there's nothing in the legislation that would permit a placement coordinator to move a person out of a facility, except if that person had an outstanding application to another facility and wanted to move to that other facility.

Mr Rogers: To respond to that, we understand that the legislation doesn't have anything in there that says it can happen, but what we are more concerned about is that it doesn't have anything that says it can't happen. All that we're asking is that through the preamble or a specific legislative statement it be clarified that the wishes of the resident, the patient, be one of the primacy concerns of that placement coordinator in his decision-making process.

Mr Wessenger: I might just ask then, what you're really looking for is some statement of consumer choice in the legislation?

Mr Rogers: Yes.

Mr Wessenger: Fine. Thank you.

Mr O'Connor: Any suggestions as a lawyer?

Mr Rogers: The PA is a lawyer as well.

The Chair: Too many lawyers around here today. On behalf of the committee, thank you for coming this morning. I'm sure that we'll see the York Region District Health Council before this committee on other issues, and we're glad that we were able to offer you your first visit. Thank you.

TORONTO MAYOR'S COMMITTEE ON AGING

The Chair: I now call our last witness for this morning, the Toronto Mayor's Committee on Aging. If those representatives would be kind enough to come forward, welcome to the committee. If you would be good enough to introduce yourselves, then please go ahead.

Mrs Diana Morgulis: I'm Diana Morgulis. I'm chair of the Toronto Mayor's Committee on Aging. With me is

Councillor Amer from the city of Toronto council, who is the mayor's appointee to the Toronto Mayor's Committee on Aging; Rita Luty, vice-chair of the Toronto Board of Health; Dr Norman Bell, chair of the subcommittee on long-term care for the Toronto Mayor's Committee on Aging; and Margaret Bryce, the coordinator and staff to the Toronto Mayor's Committee on Aging.

Before I begin, I'd like to ask Councillor Amer if she would address some remarks to you about council's position.

Ms Liz Amer: I'm here representing Mayor June Rowlands and members of city council. I will not be speaking to you on the specific issues that are before you this morning; Diana Morgulis, our chair, will be doing that. But I wanted you to know that on February 22 the city of Toronto council endorsed the presentation that you're going to hear from the Toronto Mayor's Committee on Aging this morning.

The Chair: Thank you.

Mrs Morgulis: Council also affirmed its position that it took on the long-term care reform last February 3 and 4, 1992, wherein it requested the then Minister of Health to grant new nursing care beds in the city of Toronto only to homes for the aged or nursing homes operated by non-profit corporations or by Metropolitan Toronto, and further requested that when beds are being reallocated among homes for the aged and nursing homes the proportion of long-term care beds operated by non-profit corporations and Metropolitan Toronto not be reduced.

Toronto and the Toronto mayor's committee also believe that planning for allocation and reallocating long-term care beds within the city of Toronto should be a shared responsibility between the province and the municipality. I'd like to say that the city of Toronto does wish to be involved in the planning and approval process for those beds. We want to be also assured that the province and the city will be involved in coplanning supportive housing program, which is proposed to accompany the reform in long-term care.

We are very pleased to have an opportunity to speak to you today because Bill 101 deals specifically with care provided in nursing homes and homes for the aged, but because that care is part of a much larger system, our comments deal both with your Bill 101 and with other services within the continuum of long-term care. We hope that our comments will help your committee ensure that the changes proposed in the bill conform to our collective vision of how we should care for older people in the province.

We support the proposed quality assurance plan, the plan of care, funding for the level of care and placement coordination. We believe these issues are very important.

Bill 101 mandates a new system for coordinating the placement of elderly people in nursing homes and homes for the aged. While placement coordination has operated successfully through placement committees in other regions of the province, it's completely untried in Metro. We therefore provide some comments to assist in the implementation of this new program in Metro which, by virtue of its size, complexity and diversity, has special needs, not the least of which are the ethnocultural needs, the needs of

neighbourhoods and the needs of the committed communities that have already articulated their expectations around long-term care issues.

The bill provides for a placement coordinator to be assigned to each home for the aged and each nursing home. We feel the coordinator should be a worker who's directly involved with the home rather than an employee working at some distance in a centralized office. The placement coordinator should facilitate the admission of elderly people into a home of their choice in their own community. The home should be able to respond to both personal and cultural needs. We feel that's essential.

Community-based homes should continue to offer service which is tailored to their geographical or ethnocultural communities. We shouldn't expect that people be admitted who are not members of a group targeted for service.

Both the placement coordinators and appeal board have considerable private power under this bill, and we believe the minister should appoint a citizen advisory committee to ensure that the eligibility and appeal processes are accountable to the public and to the Legislature. The committee should be established in consultation with seniors' organizations.

1140

As Bill 101 deals with an admission process to care funded by the government, it's silent on the question of residential care. As you know, residential care is not funded by the province, but by the individual senior. It's available to people who require less than 90 minutes a day of personal care and nursing care. But two-thirds of the beds in charitable homes for the aged in Metro Toronto are currently designed for residential care, and many older people who are now in residential care require considerable care.

During the consultation on long-term care reform, we often heard that the government planned to end the residential care program. We hope this bill does not mark the end of residential care programs in homes for the aged, because if it does, there are a number of consequences on the rest of the system.

There would be pressure on the groups which provide supports in the community to replace residential care. But over the past few years funding for those community services has been systematically cut.

This bill deals only with the institutional sector. It hasn't a companion bill or the assurance of political will to fund home support services and home care in the community. Institutional care can't be treated, therefore, in isolation. There has to be simultaneous progress in providing universal care in the community if the bill is going to work.

Beds will be reallocated within homes and between the homes in Metropolitan Toronto. At least one home for the aged in Toronto has said it will sell its building and move to a new location outside the city of Toronto. This concerns the Toronto mayor's committee and the city of Toronto very much. We want to ensure there are non-profit homes for the aged within the city of Toronto to serve its residents, and we believe the city of Toronto is entitled to be part of the planning process.

The council of the city of Toronto has asked the minister to forgo the expansion of for-profit care, and when beds

are reallocated, care must be taken to ensure the proportion of beds provided by charitable homes for the aged has not been reduced

The supportive housing program proposed to accompany the reform of long-term care should be introduced as soon as possible, and we believe the city of Toronto should be part of that program of planning.

In terms of the quality of care, we are pleased by the concept of quality assurance planned for each home. We've consistently advocated more accountability in the long-term care system.

Your bill says only that a resident has a right to see a plan of care, and we believe the bill should state explicitly that the plan of care requires the consent of the resident or the resident's delegate.

We feel there should be regulations developed to limit the use of physical restraints in homes for the aged and nursing homes. If restraints are to be used, they should be included in the plan of care and discussed with the person delegated to make those decisions.

Under regulations, we feel there should be a limit of moving a resident to a locked ward. It should require notice to the delegated decision-maker and to an advocate.

There is a bill of rights for residents of nursing homes and a residents' council for each nursing home. The Nursing Homes Act also requires that suspected cases of abuse be reported to the director of the nursing homes branch. We believe these same protections should have been extended to residents of homes for the aged under Bill 101.

The bill proposes to provide funding based on the level of care of each resident. This will be provided on the basis of a mix of cases in each home. However, we've been concerned for a number of years by the cutbacks in provincial funding to Metro homes for the aged. The new payment system should allow Metro to continue to provide the excellent care for which it's known. An arbitrary limit shouldn't be imposed on homes which have a number of residents requiring extra heavy care.

We applaud the introduction of a program for adults with disabilities to direct their own care in their homes. The regulations should make it clear that elderly people, including people with dementias or multiple disabilities, will also be eligible for this program. We have found that programs for people with disabilities are sometimes available only to those between the ages of 16 and 65.

Under current legislation, homes for the aged provide emergency shelter for older people. Bill 101 is silent on this. Many of those who suffer abuse are beyond 65, and we don't have emergency shelter. Shelters designed for women and children are not a suitable environment for many older people.

The Toronto Mayor's Committee on Aging has played a significant and stimulating role in public discussion, and indeed in forming the political will to resolve the problems in long-term care. We have sponsored two major conferences, hosted several smaller workshops, worked with community groups and written numerous letters and briefs, and we have made statements to the press. We've also worked within our own political system through the long-term care negotiating team and the reference group of the city of

Toronto, which are responsible to the executive committee of council

I thank you for giving us this time. I would like to invite any of my copanelists to address you, if that's appropriate. Mr Chairman.

The Chair: If anyone has anything they wish to add, that's fine. Otherwise, we'll move on to questions.

Dr Norman Bell: Perhaps you would allow me, Mr Chairman, to take note of the fact that this, Bill 101, is a birth which has been a rather long time in coming. Since the early 1980s, the crisis in our long-term care system has been quite evident to virtually everybody. There have been a variety of proposals coming forth and statements from within government—the previous government and the government before that—about the directions of this or strategies for change of this, so we are really on the brink of a major event. This will be the first visible legislative piece of paper which will give some kind of substance to all of those discussions which have been going on for so many years. And with due respect to the people who draft bills. I find this an eminently unreadable bill.

Mr Jackson: Sort of like your prescriptions.

Dr Bell: I would hope it is possible, as previous delegations suggested, to state or restate some of the general thrust of what this reform or redirection is about. Otherwise, the bill seems to get lost in a lot of detail. What need emphasis are those general principles of informed choice, of quality assurance, of accountability. There is no difference, I think, with the Toronto mayor's committee that these are desirable ends, and we would like to work with you to make sure those desirable ends are very clearly stated, are there and are seen to be there, in this important piece of legislation.

The Chair: Thank you. We'll move to questions. Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. I'd just like to ask you a question, first of all, then I'd like staff to give some clarification with respect to some of your comments.

You indicate that you think there should be a citizens' advisory committee with respect to the placement coordination operation. First of all, I'd like to indicate that it's envisaged that the placement coordinator would be subject to a board. There would be a community board that would oversee that, not being a government employee. Do you still think, in view of having a community board, that it's necessary as well to have a citizen advisory committee?

1150

Mrs Morgulis: I think boards, to be effective, are small, and may not represent the entire community. If we're looking at an area the size of Metropolitan Toronto, it's very hard to be thoroughly representative without receiving some advice as well. In terms of Metropolitan Toronto and its breadth of service, we haven't had the experience before. I think it would be wise.

Mr Wessenger: Just a question that's somewhat related to that, in connection with long-term care facilities: the question of residents councils. Do you feel that residents

councils by themselves are sufficient for accountability purposes, or should residents councils be expanded to include family and community members or would it be better to have a separate, say, community committee for each long-term care facility?

Mrs Morgulis: Now you're asking for a personal opinion.

The Chair: We welcome that too.

Mrs Morgulis: All right. This is not a position of the Toronto mayor's committee. I think residents councils are essential for the residents to have their representation, or to have their decision-maker be part of that process if the resident himself can't. I think it's also helpful to have a council of outsiders—the family, the care giver beyond the home. I don't see them supplanting the residents council.

Mr Wessenger: No. You see them as two separate committees as being more desirable.

Mrs Morgulis: Yes.

Mr Wessenger: Thank you very much. I'm going to ask Mr Quirt to comment on some of your aspects about residential funding, I think it needs some clarification.

Mr Quirt: Just to clarify three points briefly, on page 3 you mentioned that residential care is not funded by the province but by the individual senior. In fact, it's funded by both the province and the individual senior. Residents in residential care are asked to pay the full costs of their accommodation, programs and services, but if they're unable to do so, then the balance of that cost is paid by the province at 70% and the municipality at 30%.

So all the residential care beds in municipal and charitable homes will be funded under the new levels-of-care funding formula, but they'll be funded in a different way. There won't be the designation of residential care and extended care any more. All those residents, all those beds, will continue to be funded under the new system.

Second, there has not been a systematic reduction in funding for community support programs from the province in Metro Toronto. It's been a systematic incremental increase in funding for community programs for seniors and people with physical disabilities, and there will be increased funding for Metropolitan Toronto as a result of the commitment of \$441 million provincially for new long-term care programs.

The third point is with respect to the funding for municipal homes for the age. The provincial funding for the municipal homes for the aged in Metro Toronto has not decreased. Up until 1989, the funding was on an open-ended basis; in effect, municipal council decided how much provincial funding would be spent on homes for the aged in Metro. For the past four years, the province has limited the increase in funding to an inflation factor, but the funding continues to steadily increase, as opposed to decrease.

The Chair: Do you have any questions or comments before we move on to Ms Sullivan?

Mrs Morgulis: It's quite true that the level of funding has increased marginally. However, the level of care that's been required by those residents in the facilities has not increased marginally; it's increased exponentially over

time. So the effect is that there's been a decrease in funding for the care that's been needed. That's the effect.

Mrs Sullivan: Thank you very much for your brief. Actually, that last point is a concern not only in Metro but elsewhere, in that people going into long-term care facilities are entering those facilities with more acute health care difficulties, and similarly in the residential care sector.

I was interested in a couple of points you raised, one of them relating to your emphasis on the non-profit preference; indeed, you're saying the only choice. We have documentation, a summary of form 7s which are submitted by nursing homes, which divide the for-profit sector results from the non-profit sector results in the nursing home industry itself. Frankly, the significant issue about those figures is the bottom line, which shows that, per bed per day, the for-profit sector lost \$2.01 in 1991 and the non-profit sector lost \$4.86 per day per bed.

How are we going to accommodate delivery of services, whether it's for-profit or not-for-profit? In my personal view, we need a balance, because we cannot afford to take over private sector nursing homes and there's good care provided in private sector nursing homes. But how are we going to afford to deal with these kinds of bottom-line issues which are endemic to the industry, whether it's non-profit or profit, and indeed where the non-profits seem to be going more and more deeply into debt than the for-profits?

Mrs Morgulis: I wish I had a ready answer for you. I don't. I know funding is a problem, but I think the basic principle is that we didn't want to see public dollars spent to line private pockets.

Mrs Sullivan: These reports show they're not being lined. That's the trouble.

Mrs Morgulis: Should it get to a break-even point and beyond, then it would, and I think we were concerned about the individual taxpayer wanting to make sure that the money was as well spent in the public domain as possible.

The Chair: Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. That was a point I wanted to pick up on too, in terms of taking the opportunity to emphasize the importance of the private sector, the commercial sector in the delivery of nursing home services. What you just said is tell-tale of the attitude that's out there among a lot of people, that some-how private operators are lining their pockets with profit. Frankly, private operators do us a great service in this province in that the government doesn't have to put up capital dollars; they build the bricks and mortar, invest their life savings, put their good names on the line and borrow from the banks. Somehow CUPE yesterday was disturbed that the banks own most of our nursing homes. Well, maybe that's an indication that there isn't a lot of profit being made out there.

There are horror stories in the municipal sector and the charitable sector, as there are in the commercial sector. I'm well aware of that, because since this legislation was introduced, many commercial operators and many consumers have come forward with stories. I think it's unfortunate, though—and I'm part of the problem—that in these hearings we've concentrated on the not-for-profit sector bashing the

for-profit sector. I want to make it clear that we believe that municipal homes are, by and large, doing an excellent job, as we believe charitable homes for the aged are, and it was always the policy of both the Conservative governments and I believe the Liberal governments to have a mix. Although we did state a preference from time to time for the not-for-profit sector, I think the statistics show that there was a heavy and increasing reliance on the commercial sector.

It disturbs me when people say you shouldn't make a profit off health care, when in fact those profits are reinvested into expansions or keeping up the capital, for the most part. I know a number of nursing home owners, and they're certainly not rich. In fact, I wonder why they're in the business at all.

I wanted to ask you specifically about a point you raised on page 3 in your brief, where you say, "The minister should appoint a citizen advisory committee to ensure that the eligibility and appeal processes are accountable to the public and to the Legislature." Other groups have suggested that a similar mechanism be put in place. Some groups have suggested that perhaps we should put in an interpretative clause or a preamble to the placement coordination section of the bill to ensure that placement coordinators take consumer choice into consideration: ethnicity and linguistic choice and a number of other factors.

My worry about a citizen advisory committee is that we're adding to the bureaucracy, adding to the number of players in this. Would you maybe change that to a preamble, if we could work something out with the lawyers on that, or should we be looking at a better appeal mechanism?

1200

Mrs Morgulis: I think we want a separation between the service deliverer and those coordinating the services and those who are hearing the appeal. If that can be separated in some way in a preamble or in legal terms, that would satisfy the appeal end of things. As I said before, if you can accommodate it in a preamble to have the citizen advisory looking after the needs of the Toronto region, I think that would help, but in a bill you're looking for something that's universal for the province; you're not looking for specifics for a region or an area.

Could I ask you if we could have a copy of that summary report you referred to between the for-profit and the not-for-profit nursing homes?

Mr Jim Wilson: I think Mrs Sullivan referred to that. She'll be happy to give you a copy of it.

Mrs Sullivan: I'll get a copy for you.

Mr Jim Wilson: The last question I have is really a general question. Given the track record to date on funding from various governments, it seems to me that we have mandated in this bill levels-of-care funding but not necessarily levels-of-care funding, because it's a limited pool of money. What's your confidence level that the funding will actually match the higher levels of care that I believe you're going to be asked to do? Mrs Sullivan put it kindly when she talked about higher levels of acute care. Frankly,

you're going to be asked to look after older and sicker people. Before they can even get into your homes, if one looks at the eligibility criteria, they must exhaust all community-based services—it's very much a medical model—and have to be in pretty rough shape, I think, before they're going to be allowed into a home.

Mrs Morgulis: My experience is not working in a home, although I rent office space within a home. I run a not-for-profit charitable community-based organization providing home support services to the elderly and elderly persons' centres activities.

I agree with you, it is a medically based model. It is not everything that the Toronto mayor's committee heard and wished to have as a model. We were looking for a social service/medical/holistic model. If this is what we have to work with, you're right, it's going to be very, very few who can make and manage all the entry criteria, and it's going to fall on to the community services such as ours to provide that catch-up and fill in the gaps.

Mr Jim Wilson: I think the doctor wants to make a comment.

Dr Bell: I just wanted to make a personal observation. To discuss these matters in terms of profit and not-for-profit homes is important, but it is not the only distinction that needs to be made. One of the perennial problems is the blockage in the system at the acute-care level of hospitals, with sometimes 20% of their resident populations being elderly people. These issues need to be thought of in terms of the fact that the people don't go away but get shoved into other places, so one has to think about where it will pop out next if some action is taken at one level.

That comprehensive view of the whole system, including the home care community-based services, needs to be always kept in view, and we think a local community input is pretty essential to understanding those kinds of transfers of populations and finding the best possible solutions. There is no magic wand in this area, but we believe that with an active citizens' group and committed government at the city and the metropolitan level, solutions can emerge from these kinds of discussions, given the right legislative backing.

The Chair: Thank you very much for those comments. You noted at the end of your brief about the conferences, workshops and various things you've done. I believe I had the pleasure of addressing one of those conferences at city hall.

Mrs Morgulis: You did.

The Chair: I was struck by the number of people who attended the conference that particular day—if I recall, I think the whole place was packed—and the interest your body has really furthered in terms of this whole discussion. You have done an excellent job, and we appreciate very much you coming before us today and helping us with ours. Thank you again. The committee now stands adjourned until 2 o'clock sharp.

The committee recessed at 1206.

AFTERNOON SITTING

The committee resumed at 1403.

ADVOCACY CENTRE FOR THE ELDERLY

The Chair: Good afternoon. We begin the Tuesday afternoon session of the standing committee on social development. We're here to review Bill 101 on long-term care. Our first representatives this afternoon are from the Advocacy Centre for the Elderly who have shamed all of us members by not only being here, but being at the table and ready to go. We welcome you to the committee. If you would be good enough first off to introduce yourselves for Hansard and for the committee members, then please go ahead with your presentation.

Ms Susan Chernin: My name is Susan Chernin. I'm with the Advocacy Centre for the Elderly. With me are George Monticone, a staff lawyer at the advocacy centre; Elizabeth Budd, a student at York University who has been assisting us in a volunteer capacity; and Evelyn Turner, a member of our board of directors.

The Chair: Welcome to the committee.

Ms Chernin: We'd like to thank you first of all for this opportunity to present. We recognize that you will not perhaps hear anything particularly new today since you've been sitting here for almost a month now listening to people's comments. However, we do hope to reinforce some particular areas of concern.

Our concerns are simple and direct and are all focused on the need for a more client/consumer-directed process. To allow as much time for questions, you have a brief that we have submitted. I will just highlight some of those areas and read the recommendations. Then we can have some time for discussion.

The first area is conditions of admission, and the first among those is consent to admission. We consider this to be a fundamental right which must be protected. It is critical to a consumer-directed process that it be in the body of the legislation. Although it is obvious to all of us sitting here that it is unlawful to admit, discharge or transfer an individual without his consent, this is not obvious to many service providers and is not obvious to all seniors, and it happens all the time. The problem is not with the long-term care facility usually; the problem is usually with the acute care facility putting a lot of pressure on individuals to vacate.

It is too important a principle to be relegated to the regulations. To not embrace consent in the body of the legislation is to feed the confusion and to encourage that this fundamental right be violated. Our first recommendation, therefore, reads as follows:

We recommend that subsection 9.5(5), and subsections 18(5) and 20.1(5), respectively, in Bill 101 be amended and read as follows:

"(5) A person may be admitted to an approved charitable home for the aged, municipal home or nursing home only if,

"(a) the person or his or her legally authorized substitute decision-maker has consented to placement to the home."

You'll note that in (b) and (c) these are simply the very same conditions already set out in Bill 101. We've just numbered them (b) and (c) because we actually consider them less important than the first point, which is consent.

The second recommendation under this heading is:

We recommend that if there are reasonable grounds—actually, I forgot to make a reference to this point. As well, under the conditions of admission we note that there may be grounds for refusal by the licensee. We are at a loss to know what those grounds might be, but we are concerned that they be set out in the regulations and not set out in the statute, so we make a further recommendation on that point, which is:

We recommend that if there are reasonable grounds under which a licensee may refuse admission to an applicant, these grounds be spelled out in the statute and not be relegated to the regulations where they may be changed without the benefit of public scrutiny and debate. We further recommend that applicants have the right to appeal a refusal to admit on the part of the licensee.

The point really in this section is that these matters are too important to be relegated to the regulations where they can be changed by technicians and not through public debate and public scrutiny, as is happening right now.

The Chair: I may have misunderstood, but I thought with the second one you say you want that spelled out in the statute, not in the regulation, so it's the same for both.

Ms Chernin: It's the same for both. Actually, the more important issue is consent to admission, frankly. It's just that it comes under that heading.

The Chair: I think I misunderstood because when you first started to speak on number 2, I thought you had inverted it—

Ms Chernin: Did I?

The Chair: Anyway, by my interjection, it makes it clear.

Ms Chernin: If I did, please let the record show—

The Chair: It may have been the Chair was asleep or something.

Ms Chernin: Anyway, both are significant.

The Chair: Anyhow, that's clear. Sorry; please continue.

Ms Chernin: Feel free to interrupt at any time.

The second area of concern is the appeals of decisions regarding eligibility and placement. Upon an initial reading of Bill 101, there was some excitement about the appeal process until one realized how limiting it was. In our experience eligibility is not the most common or the most contentious issue. We have had only two to three cases in our nearly 10 years experience at ACE regarding eligibility issues.

Placement, on the other hand, is a very contentious issue. Rarely does even a week pass that we haven't had some intake or call regarding concerns about placement. It is critical to a consumer-directed process that this be incorporated in the act

Because we are unclear about the shape of a long-term care structure and we don't know what bed shortages there may be or what limitations there may be on community-based services, eligibility may indeed become a very contentious issue in the future, so we are suggesting that this remain.

Therefore, recommendation 3 reads as follows:

We recommend that an appeal mechanism be established in the statute to allow the consumer or his legally authorized substitute decision-maker to appeal decisions of the placement coordinator made in connection with the authorization of placement to specific long-term care facilities and that this appeal mechanism be in addition to that provided for appealing decisions regarding eligibility.

1410

The third area of concern is the nature of the proposed appeal process. On its own, it is simply too formal. We need something more tailored to meet the needs of this particular client group. Many of these individuals, we must anticipate, will be facing some infirmity. They will lack confidence and often language skills. We need something that's more easily accessed, more expeditious and also one which respects confidentiality.

Mediation and arbitration are two conflict resolution mechanisms that should be considered. The board can be a further or an alternative safeguard to this process.

Therefore, recommendation 4: We recommend that a less formal conflict resolution process be established as preliminary to or as an alternative to an appeal to a statutory board to address disagreements between the placement coordinator and the applicant with respect to eligibility, particular placement or the receipt of community-based services.

Recommendation 5: We recommend that an appeal process be in camera at the discretion of the applicant.

We've alluded to community-based services and we turn to that now as the next area of concern. As you're all well aware, those of you who've been involved in long-term care reform for many years, one-stop shopping has been a theme. We're not clear if the placement coordinator is the vanguard of this structure. We want to know whether or not they're going to be the gatekeepers to community-based services as well. If so, a conflict resolution process must be in place for them as well regarding community-based services. Furthermore, it will be important that a person seeking community-based services is not detoured to a placement which is deemed "more appropriate" by a mechanism of refusing to provide services in the community.

Recommendation 6: We recommend that Bill 101 state clearly and unreservedly that the placement coordinator cannot refuse a person access to community-based services on the grounds that placement in a long-term care facility is more appropriate.

Recommendation 7: We recommend that whatever method of dispute resolution is adopted in Bill 101 for

resolving disputes regarding eligibility for and placement in a long-term care facility be adopted for resolving disputes regarding the appropriateness and amounts of community-based services.

The fifth area of concern is the additional protections for residents of charitable institutions and homes for the aged. In non-care facilities tenants have protections regarding rent increases and eviction under the Landlord and Tenant Act and the Rent Control Act. Nursing home residents have protections regarding discharge, restraints, treatment etc in the bill of rights. The bill of rights should be extended to charitable and municipal homes for the aged and enforcement mechanisms should be considered. Similarly, Bill 101 should incorporate a direction to establish residents' councils.

In the executive summary I should point out that—I don't know if you say typographical error now or just computer error—numbers 10 and 11 are actually a repetition. Number 10, you can find in the body of our brief.

Number 8 will read as follows: We recommend that the bill of rights presently embodied in the Nursing Homes Act, RSO 1990, as amended, be incorporated in Bill 101 to give protection to residents in both charitable homes and municipal homes for the aged.

Recommendation 9: We recommend an enforcement mechanism for the bill of rights.

Recommendation 10: We recommend that Bill 101 include provisions directing the establishment of residents' councils in both charitable and municipal homes for the aged similar to those provided for in the Nursing Homes Act, RSO 1990, as amended, specifically section 29.

Finally, our concern about the plan of care: Again, the plan of care should reflect a consumer-directed process. Presently, as it is set out in legislation, it is passive. It is to be given to the residents at their request. We do recognize that such participation in the plan of care is set out in the standards of care, but again these are policy directives and they are subject to change. It is important that the legislation itself reflect the importance of direct input by the consumer.

Recommendation 11: We recommend that Bill 101 be amended to reflect the importance of residents or their legally authorized substitute decision-makers participating directly in the development of the plan of care.

So I suppose if there's a theme to our recommendations, it's that it should be consumer-directed and that this consumer direction should be incorporated in the body of the legislation. Although we all know that there are safeguards in other places, other people don't respect those safeguards, and they really must be stated clearly and unequivocally.

We're happy to respond to any questions.

The Chair: Thank you very much both for the specificity—and I hate that word—of your recommendations, which I think address some very clear points, as well as the text, which we'll be able to consult as well.

We'll begin the questioning with Mrs Sullivan.

Mrs Sullivan: Thank you. I thought this was an interesting brief, and I have two questions or comments.

The first is with respect to your suggestion that the consent of the person or the person's substitute be involved before the person is placed. I would think perhaps not right now, but at some point, because a couple of other organizations have made this point as well, it would be useful to have an opinion from legal staff as to whether in fact a placement in a home is covered by either the common law of consent to treatment or, when the consent to treatment bill comes into force, if in fact one is consenting to a course of treatment in consenting to a placement in a home, and if they're linked up, if it's automatically covered or not. You're not the first group to raise that issue.

The second issue that I wanted to raise with you is the appeal process. In my view, and we will be talking more about this in our own caucus, the appeal process that's presented in this bill is a flawed one. The Health Services Appeal Board is one that is perhaps not an appropriate mechanism of appeal when the decisions may in fact be highly personal, highly regional, and where that seems at arm's length, very formal and so on, and the only alternative after that, of course, is Divisional Court. When we're dealing with people who are speaking about choices which, depending on how cognizant they are, may well be life choices or may well be choices leading to a happy death, if you like, the appeal process is something that I think one has to be cautious about. I don't think this is the right one. I think you've been talking about involving people in something that's less formal. Can you talk a little bit more about that?

Mr George Monticone: If I may speak to that, yes, I think there is a need for something less formal. Perhaps the most urgent need here is that the appeal process be expeditious. We're talking about people who are suffering infirmities and in situations that may be less than ideal wherever they're living, at home. So there's a real need for that.

There's also a need to eliminate as much as possible the intimidation factor, and I can't overemphasize that. Individuals who are not well, who are facing the possibility of a move to a home, which they may not regard as a positive thing, will be intimidated by the need for a formal process. If there is some way that we can find to make it less intimidating, I think it's absolutely critical to do that.

1420

I believe in the United States there have been experiments with mediation in situations like this. Perhaps that's appropriate. The problem with mediation, however, is that a decision doesn't necessarily ensue, and if the parties cannot come to an agreement, then nothing is resolved.

Hence we might want to look to something more like arbitration. The reason I mention that is because the arbitrator may be given some responsibility to fact-find and take some of that responsibility off the shoulders of the individual who is appealing. That may make it much less intimidating.

I don't have the final solution here. We are really inviting you to think about these as creative alternatives to a straightforward statutory board.

Ms Chernin: Also, there could be a number of different alternatives that might be available, depending upon

the circumstances, and we're also not dismissing the possibility of a board being appropriate under some circumstances or as an eventual process. If you're going to be embracing things beyond eligibility, I think it will break down—if you're going to be covering placement, which I think you should be doing.

Mrs Sullivan: Certainly we want to think more about this as being a major flaw in the bill, and if you can put your mind to it a little more and provide us with more information on that particular aspect, I think that would be useful.

Mr Jackson: First of all, I'd like to thank you for the focus of your brief, for there is a lot more, I know, you would like to have commented on. But in the context of advocacy it's very individual-oriented and -directed, and I appreciate that.

That's why I want to explore further recommendation 1, which I appreciate your wanting in legislation and not in regulation: the context of the person's right to consent not to go into a facility. I want you to cast your mind to the notion of the discharging, and although you don't come right out and say it, it's implicit in discharging from a location and having a certain impact on that decision. Is there a reason you didn't include the discharging from a facility, and just whether your recommendation 5(a), "The person or his or her legally authorized substitute decision-maker has consented to placement to the home"?

Ms Chernin: Clearly, most placements—I shouldn't say most placements, but maybe most placements—come from some other type of facility and it's usually an acutecare hospital. In my work as an institutional advocate for over seven years, it's been very helpful even though, as I say, we know it's against the law to transfer someone involuntarily. It simply is, but there are tremendous pressures on these individuals to vacate the bed they're taking in an acute-care facility. We're not suggesting they say no to placement; simply that they consent to placement, which I think is a different twist which means they're involved in the process of choosing. There may be limited choices, but they will be choosing.

Mr Jackson: You can't give consent unless you're informed.

Ms Chernin: You have to be informed.

Mr Jackson: That's the principle in law.

Ms Chernin: Exactly. We're not saying that someone can say, "I'm going to stay in the hospital for a long period of time." I think the concerns people have is that they'll be bed-blockers, which we know—

Mr Jackson: That scenario I understand. I guess I could have been more specific. I'm concerned about a growing acuity rate in a system that says, "We think, even though you've been in this nursing home for two years, you really don't need to be here and therefore we need you to leave in order to make room for someone else."

Ms Chernin: In a nursing home?

Mr Jackson: Or any kind of facility where there's a greater acuity rate and the placement coordinator wants to deal with persons of greater need, which is the phrase constantly floated out during these committee hearings, "Don't you agree that the person with greatest need should have access to that bed?" Well, that theory taken to its logical conclusion means that persons in institutions who are bed-blockers or inappropriately placed should be asked to leave, should be encouraged to leave, should be forced to leave, because there's no longer an insured service where you can appeal; it's now a contractual agreement and your contract evaporates as soon as the legislation is implemented. You have to sign up a new contract.

I don't know if you've put your mind around that case scenario, certainly the premature discharging—even my own hospital, Joseph Brant hospital, has misled patients, put them into homes that were in receivership and told them there would be no fees, then all of a sudden, day one, they've got all these fees. We know those cases. I'm talking about a system that is contracting—the legislation says there are no new beds being injected into the system—and a growing acuity rate, a system that has absolute control over who goes in and who may have to be asked to leave. That's really what I'm asking.

Ms Chernin: Indeed, and that's what we put our minds to every day.

Mr Jackson: I'm asking for your help in the context of legislative language so that we grandfather people who are currently in institutions from being discharged. Those kinds of things could occur if you look at the current legislation as it's written. I haven't found the answer; I just know that you people have the legal minds and understand advocacy and how vulnerable these people who are currently in facilities could be.

Ms Chernin: Indeed. With the bill of rights, there is a right—I can't remember it right now; Geoff probably does—that says you can't be discharged without participating in that process, which is why we're suggesting that the bill of rights be incorporated with the charitable homes and the municipal homes for the aged.

We don't have answers to the big question of how we're going to get few resources to meet the needs of many people. However, we do feel that whatever system is set up, it has to be one that is consumer-directed, where there is active participation and it's not a best-interests system. Somebody's going to have to be looking at the best interests of the system, but we're looking at the clients' direct input into that. So there must be consent to any type of admission and clearly to discharge.

With hospital situations, in cases where doctors have said, "I'm simply discharging that person," it has been quite valuable to be able to say, "Well, they're not consenting to admission." So it has been able to empower the individual in a way that has been quite fruitful, and I think we need to make sure that is incorporated in the legislation.

Mr Stephen Owens (Scarborough Centre): Thank you for your excellent presentation. You raise some questions that I've been struggling to answer myself.

In terms of the devolution of patients from acute care facilities, I'm wondering if you've had an opportunity to think about the kinds of protections one could also build in at that end of the process while ensuring that the patient's

soon-to-become resident rights are kept whole. Currently, there's an ability for hospitals to levy per diem fees and other such items against the patient. How do we protect from that end as well so that the individual is able to exercise whole and cognizant rights of consent?

Ms Chernin: That hits it right on the head. I think some facilities have found respectful ways of addressing that. I've had umpteen cases of individuals saying, "If I don't take this placement, which I don't like because I don't feel comfortable with it and I'm waiting for something else, I'm going to be hit with the OHIP per diem rate."

I stand to be corrected on this because it's information I'm getting from clients—I'm not double-checking it necessarily—but some of the hospitals in York region are actually charging the long-term care rate for people who are there for a month or two months or are awaiting another placement. So it's not encouraging people to stay in an acute care facility because it's free, but it also allows them to participate actively in the choice that they do make and that eventually comes to be.

We all know there's a phenomenon called transfer trauma. It's not a good idea to be transferring people from one place to another. We also know it's hard to transfer from one place once you're in. You go lower on a priority list. The person who arrives at the long-term care facility from an acute care facility who has participated in the process is a healthier, happier individual. There may be ways to balance the books so that the taxpayers are also being protected.

1430

Mr Owens: Again, in terms of the process you'll take away from here when you leave today, I'd really appreciate some suggestions around language that we could take a look at inserting.

I also enjoyed suggestions with respect to residents councils, and again in terms of projects that I'd need assistance with in ensuring that residents councils are both effective in terms of enforcing, again, the rights of residents—you talked about a bill of rights—enforcing that bill of rights, but on the other hand, ensuring that there isn't arbitrariness or discriminatory activity that takes place by a residents council.

What kind of protection would you also build in? I think it's fine that we can mandate residents councils, but how do you build in that effectiveness without an arbitrariness as well?

Ms Chernin: We have lots of discussions, and I know the Ontario Association of Residents Councils has already presented to you. In the present Nursing Homes Act, there is actually a section which allows the government to appoint individuals to assist residents councils. I stand to be corrected, but I don't know of anyone who has been appointed.

There's no question that these residents councils need some assistance, and it would be far better that it be someone not necessarily within the facility, someone outside to help empower them to make decisions so everyone doesn't become institutionalized. I think there have been recommendations and proposals put forward by the Ontario Association of Residents Councils which you know we would certainly support.

In terms of your other point, which is an interesting one and I will think about it more, about giving more safeguards, I guess as many safeguards as there can be in any democratic process short of dictatorship.

Mr Owens: For instance, in the Ontario Labour Relations Act there is a mechanism to add a means to remedy for members who feel they have been treated in an arbitrary or discriminatory manner by the particular union. I think we're all human. For instance, if a residents' council decides that everyone should wear polka dots on Thursday, there may be somebody who doesn't want to subscribe to that—

The Chair: Is that a recommendation for the committee?

Mr Owens: —kind of a recommendation or may not support a particular direction that a council may be headed in. I'm concerned also that the right of an individual to dissent in a reasonable manner be respected.

Ms Chernin: Actually, I'll discuss that with the Ontario association. I know they are going to be submitting some further points to you, so I will talk to them about that. It's an interesting one.

The Chair: Thank you. Point of clarification, parliamentary assistant.

Mr Wessenger: First of all, before the point of clarification, I'd really like to thank you for your very specific recommendations. They are certainly well thought of and will certainly be given very serious consideration. The only thing I just want to clarify is that this legislation does not in any way allow the discharge of individuals from long-term care institutions by reason of their not being eligible for that institution. I just thought I'd mention that.

Ms Chernin: I thought there was a section about refusal, that the licensee can refuse. Is that the section you are talking about?

Mr Wessenger: No. It was just the comments made by another member.

Ms Chernin: Oh, another member.

Mr Wessenger: I just wanted to ensure that it was clear that residents in existing long-term care residences and those who are admitted in the future would not be discharged for arbitrary reasons.

Mr O'Connor: We are not going to send them back to the farm.

The Chair: Thank you very much for coming. I think a number of people have indicated that if you have any other brilliant thoughts along the way, drafting or otherwise, please get them to the committee.

Ms Chernin: Thank you very much.

VICTORIAN ORDER OF NURSES, YORK BRANCH

The Chair: I would next like to call on the Victorian Order of Nurses, York branch, if they would be good enough to come forward. Just for the record, as our next witnesses come forward, we are referring to York region

and not to the city of York, which gets a bit confusing sometimes.

Mr O'Connor: All members from York region understand that.

The Chair: That's right. The members from York region understand that but not—

Mr Jim Wilson: This is York region day.

The Chair: That's right. An excellent day.

Mrs Teddene Long: I understand we're in good stead, with the district health council being here.

The Chair: May I welcome you to the committee, first of all. If you would be good enough just to introduce yourselves for Hansard and for the committee members, then please go ahead with your presentation. We have a

Mrs Long: First of all, may I say that the York branch of the Victorian Order of Nurses appreciates the opportunity to make this presentation to the standing committee. I'm Teddene Long and I'm the executive director of the York branch of VON. Accompanying me today are John Wilson, York branch board member and chairman of the external relations committee of the board, and Beverly Lamont, whom I really think you probably want to grill later on, the director of the York Placement Coordination Services, which is administered by the York branch of VON.

The Chair: I should assure Mrs Lamont that we will not grill her. We may ask some questions, but we won't grill her.

Mrs Long: Oh well, I think maybe a little bit of grilling might be good.

Mr Jim Wilson: Roasting.

copy of your brief.

Mrs Long: It's been sort of a dull day around our offices.

Mr Jim Wilson: Oh, it hasn't been dull here.

Mrs Long: The York branch of the Victorian Order of Nurses commends the government for its commitment to amend certain acts concerning long-term care in Ontario. The bill is the first piece of reform legislation in long-term care redirection.

We are aware that VON (Ontario) and other VON branches have responded to the invitation by the committee to present written submissions. It is not our intention, and you can all breathe a sigh of relief, to review the information from these submissions but to focus our comments on how the proposed legislation may affect the residents of York region.

As you are aware—and this is just a little bit of a plug for VON—the Victorian Order of Nurses of Canada is a national, not-for-profit, charitable, community-based organization that has indeed been in existence for 95 years. The York branch is quite a young branch, being only 32 years old. The staff of professional registered nurses and registered nursing assistants and support workers represent a diversity of ethnic backgrounds, education and experience.

The board of directors of the VON York branch represent a cross-section of the region and provide a variety of skills and experience in the governing of the branch. The

board is responsible for fiscal management and strategic planning activities.

The York branch is dedicated to excellence in all services and to continued leadership in meeting the changing needs of the residents of York region. Service is provided by a committed VON team of staff and volunteers using modern technology and practices.

In the last six months the branch has taken the lead in promoting partnerships with other health care providers in the region. Strong ties have been developed with acute care hospitals, the public health department, the York region home care program and other agencies within the region. The staff and board of the branch are consulting with the newly formed district health council. As a matter of fact, they will be attending our board meeting in the latter part of this month. Strategic planning by agencies or institutions in the region has actively involved other key health care providers.

With this background information regarding the York branch, we would like to address the following areas of concern regarding the proposed legislation, Bill 101: ethnic groups, fragmentation of care, quality management and regional planning.

Ethnic groups: The legislation does not address the cultural, religious or linguistic needs of consumers. As you know, York region has a number of ethnic groups, including a large Asian and Italian population. The consumer needs information available in his own language, both verbally and in print. As well, the elderly ethnic consumer needs to be assured that admission to an institution, as described by Bill 101, will consider his needs for familiar surroundings and activities.

Failure to provide adequately for the needs of the ethnic groups may result in families and consumers deciding to continue caring for the elderly consumer at home, which may be detrimental to the family and to the elderly consumer. This would of course have an effect on another segment of the long-term care reform, which is probably now known as home care.

Recommendation 1: That the legislation address the cultural, religious and linguistic needs of consumers.

Fragmentation of care: The proposed legislation addresses one aspect of the long-term care system. This morning, when I was trying to play devil's advocate with myself, I described this as a jigsaw puzzle without a picture. In other words, I have something over here and I know it all goes together, but I don't know how to put it together. Without some understanding of the long-term care framework, the proposed legislation appears to fragment the system. The government needs to provide an overview of the entire system to enable intelligent response to one aspect of the long-term care system.

Recommendation 2: That the proposed legislation be held until other proposed legislative changes are presented to ensure that the system is fully integrated.

1440

Quality management: The proposed legislation does address the need for a quality assurance plan for the institution; however, there is no mention of consumer-centred outcomes. As well, the proposed legislation clearly outlines the powers on inspection, which have a punitive connotation rather than an incentive to provide quality care.

Recommendation 3: That the proposed legislation include the use of quality management concepts to ensure quality care.

Regional planning: The proposed legislation does not delineate the eligibility of a consumer for admission to a specific institution. Again, in thinking about that this morning, I asked myself, if a consumer in York region requested admission to a home for the aged in Metropolitan Toronto due to the location of family members, would this be considered?

At the present time in York region, a significant number of residents reside in the south of the region. However, the location of the majority of the institutions is in the north of the region. By the way, at the end of your package you have a map of the region with the population over 75 and the appropriate beds in the areas. It is difficult for family and friends to visit residents in institutions unless they have access to an automobile. Public transportation in the region is not always available, which means that taxi transportation is required, at a significant cost.

The needs of the ethnic groups in York region also need to be mentioned here. Should long-term care institution planning be done on a regional basis or will there be some crossing of regional borders? Again, when I was thinking about it this morning, I was thinking of the Jewish population in Thornhill wanting to go into a home for the aged such as Baycrest.

Recommendation 4: That planning for the location of long-term care institutions needs to be addressed provincially and locally by the government.

This ends our written submission. Again, I would just like to thank you for your invitation. We would be pleased—and when I say that, I mean those on my right and my left—to respond to questions.

The Chair: Thank you very much. In particular, Mr O'Connor and I probably want to say thank you for the map, which is extremely useful. If we get lost going home, Larry, we've got something we can consult.

As you noted at the beginning, we have had a number of presentations from VON groups around the province, and it has been, I think, particularly useful to get the perspective in terms of exactly where you operate. That is very helpful.

We'll begin the questioning with Mr Wilson.

Mr Jim Wilson: Thank you for your presentation. I border on York region to the north, given that I have the other side of Highway 9 from King township. I am from King and am aware to some extent of the needs there. It does strike me, though, that you have some services that we don't have on the other side of Highway 9. We don't even have the luxury of complaining about losing or having cutbacks to some of the services, because we just don't have them.

None the less, I think you make a very good point in your last recommendation, which talks about planning. Is the placement coordination service that you have now strictly for the region?

Mrs Beverly Lamont: We accept residents from outside the region providing they have relatives in the region, because we feel that for support, people should be intact with their families for visiting purposes.

Mr Jim Wilson: In your reading of Bill 101, how do you see this? Is it that there's going to be more centralization and that if you live in Kingston, you can apply to Kitchener if there's a particular home that suits your ethnicity or your linguistic qualities?

Mrs Lamont: I would hope so. That's why it's so important, as Teddene has mentioned, that the planning be done provincially. The number of beds, so to speak, across the province has to consider the provincial needs as well as the regional needs. If you just do it on a regional basis, then you are going to have places where you're short of beds and other places where there are too many.

Mr Jim Wilson: I asked you this question because I think you're one of the first groups to emphasize the need for province-wide planning, and it certainly ties into your point regarding fragmentation and the piecemeal fashion in which long-term care is being presented by the government.

I also want to talk briefly about your recommendation that the legislation be put on hold. A number of other VON branches had the same recommendation. The problem we have as legislators is that the game's changed over the past year and the government's now tied this legislation to funding, and we have friends, obviously, in the nursing home sector who need the money. Have you thought of that side of the equation? With that in mind, would you still want to see the legislation on hold?

Mrs Long: I considered this when I was speaking. Mr Quirt over there will tell you that in my former life I worked in the division, so I am aware of government process etc. But it seems to me that if you don't have a sense of the whole, how can you be working over here on a piece? I guess what you're asking is, do we trust the government? I guess you would get a lot of different answers on that one if you went around the room.

Mr Jim Wilson: My political advice would be, don't touch it.

Mrs Long: Exactly. I'm not about to make a comment.

Mr Jim Wilson: But you agree that we're in a catch-22.

Mrs Long: Yes, you're in a catch-22.

Mr Jim Wilson: And it's unfortunate.

Mrs Long: Coming down this afternoon, Mr Wilson asked me, "Do you think they're going to buy this?" I said, "No, but I have to say it."

Mr Jim Wilson: I appreciate your frankness. Thank you.

Mr O'Connor: I want to thank you for coming down today. Indeed, it has been a bit of a York region day, and I guess we're going to have a little more of York later on in the week.

Earlier we did hear from the district health council. In their presentation, there was a little concern. We've heard concerns about the role of the placement coordinator. You talked about your young history. Well, the DHC's got even a younger history, and we're just getting to the point—in fact, last night they had a meeting to try to make plans for establishing the subcommittee and trying to get some guidelines on how to establish the subcommittee for long-term care.

I don't know whether any of you managed to make it there last night. I was just wondering if you had any suggestions that might be useful—I see that a person from the long-term care office for our region is here—that maybe you could pass on to the committee today, because it's something that I know we have a concern about.

Before you do that, just one comment to the framework policy: Should that not be available, hopefully before this gets into the Legislature in April?

The Chair: The Chair notes that a head went up and down, meaning yes.

Mr O'Connor: So that will be something we'll be able to use in the debate in the Legislature as well. Could you make some comment?

Mrs Long: I've thought about what you're asking me. To be very honest, Bev and I have a meeting with Graham this week, and as a matter of fact, we have a meeting with Jack next week. So yes, it's on our minds, but we really haven't had an opportunity to brainstorm and put anything together.

Mr O'Connor: When we take a look at the bigger picture, not only is it not included in the bill, but up in York region, it's still in its infancy anyway and we're trying to develop it as we go. I think perhaps we're at an opportune time in York region to work with the brand-new DHC and make sure the direction we do head in is going to be the right direction.

I'm glad that the VON is going to be there helping in this process, because I think it does require input from the entire region. As the map shows, we are a large region and the beds are dispersed throughout the whole region, so I think it's opportune that we're starting at this time.

The Chair: Ms Fawcett.

Mrs Joan M. Fawcett (Northumberland): Thank you for your presentation. A couple of things: I know the work you do is fantastic. Everywhere we have gone we've got the message that the VON—well, you invented home care. I just wonder about rural Ontario. Do you see that rural Ontario is going to be adequately served? Do you see anything that we should possibly be looking at? Right now, I know of large gaps where the service isn't as good. I shouldn't say it isn't as good; it just isn't there. I have some concerns, being from a rural riding.

Also, I asked the question of a couple of VON chapters that were before us about the program on television where in Saskatchewan the VON is no more and the government has taken over the service. I was told that wouldn't happen here in Ontario, so I put it in the back of my mind, yet just today I was talking to a resident in Scarborough who said, "Why are they getting rid of the VON?" I said, "What do you mean?" Probably they saw this same show; at least I'm assuming that's what it was. Have you talked about

that? Have you any fears about that, as we do have the same kind of government in Ontario right now?

1450

Mrs Long: I don't think the Victorian Order of Nurses is any different than any other organization today. I can go to all of my colleagues in all three hospitals—I have done this—and jobs are being taken away. We don't have the money.

VON, like any other organization, any business, has got to prove it's economically viable. They've got to manage their business and do a good job. To say that yes, we have been providing health care, visiting nursing care in particular, for a number of years, not only in the region but in the nation—I think we have to look at proving that we provide a better quality of care than some of our competitors, be they not-for-profit or be they for-profit. That's where it's at. The organization that goes out and hires and trains its workers, does performance appraisals and looks after the dollars is going to be here. The one that doesn't, isn't. It's just that simple, in my mind.

I think the Victorian Order of Nurses from Ontario has done a very marvellous job. In fact, two years ago I probably would not have joined that organization. It's a different organization today. That's a personal comment and probably shouldn't be shared with this committee, but you've asked me the question and I'm answering it. I would probably have stayed with Mr Quirt and company down in the division, but I didn't. I swung.

Mr Jim Wilson: Quirt's cheques will start bouncing.

Mrs Long: Is that right? Well, I might only be working four days.

Mrs Fawcett: My fear is that if the government takes it over, then all the wonderful volunteers you also have access to will not be there. That certainly has been expressed too.

Mrs Long: Yes. I have to tell you, the volunteers, not only our own board members but the volunteers who come in to help us do things in the office, are incredible, the number of hours they provide, and they love it.

I have one gentleman who had a stroke at the end of November. He comes in every morning and does all the shredding in the whole branch. He climbs up a set of stairs; if you've been to our office, Mr Beer, you know it takes a giant to climb those stairs. He's had a stroke. He climbs up those stairs and he does the shredding and he goes home. I'm probably coming in a little after 8 and he's leaving. He's been there since 7 o'clock. Incredible.

Mrs Fawcett: The human touches.

The Chair: I can understand about the stairs. The parliamentary assistant has a clarification.

Mr Wessenger: I just wanted to answer the question you asked in your brief about the consumer in York region being entitled to apply to Metropolitan Toronto. The answer is of course yes, because the whole idea is to give consumer choice across the whole province to consumers and not to limit it geographically.

I'd ask the Chair's indulgence. Legal counsel indicated they could give clarification to a couple of points, and seeing as it's not 3 o'clock, I'm wondering if this might be an appropriate time to do it.

The Chair: I'm in the committee's hands. If that's agreeable, we can do that. Before doing that, I'd say thank you for coming in and for your presentation. We really appreciate it. If our reading is anything, I think the VON's going to be around for a long, long time.

I'll then ask the parliamentary assistant and legal counsel to comment on a couple of the questions that were raised, I believe by Ms Sullivan, was it?

Mr Wessenger: Yes, there was one question raised by Ms Sullivan about the common law of consent with respect to admission to a facility. In addition, there was a point raised yesterday with respect to the gender aspect of homes for the aged. I think we need a clarification on that point.

Ms Gail Czukar: I don't know if Γ ve said my name today for the record. I'm Gail Czukar, lawyer with the Ministry of Health. I'm not sure what all the questions were regarding consent, whether the common law of consent would apply to the admission of a person to a home. On that, probably opinion would be divided. Usually, the law of consent has to do with consent to specific medical treatment, and it's usually required of practitioners who want to administer the treatment and that sort of thing.

However, my view would be that you need legal authority if you want to send someone somewhere involuntarily. My view would be that you don't need to have a specific requirement of consent in this bill, because we don't have any power to send someone who doesn't want to go, who doesn't give his consent.

Having said that, I know the concern the presenters from ACE raised—I've had them present that concern to me elsewhere—is that if there isn't a specific requirement of consent, facilities often ignore that or just aren't cognizant enough of the need to have a specific and articulated consent. That is something to consider, and that has been put forward by that group specifically for that reason.

With regard to the law on it, I don't think there's a case which talks specifically about consent to admission where there's no authority to send someone involuntarily to a facility in the statute, but the argument for having it made explicit is that that way there's no doubt about it.

Mrs Sullivan: Okay. Then I will ask what the difference would be between a person providing consent for admission to a hospital for a course of treatment and a person providing consent to a nursing home where a course of treatment is determined through the plan of care to which consent will be given.

Ms Czukar: Yes, you did ask specifically about whether the requirement in the Consent to Treatment Act would apply, and of course it would apply if you have a health practitioner who's proposing a treatment or a course of treatment that would fall within that act. In most cases, that would not be the case. When a placement coordinator is considering someone for admission, it would not be for the kind of treatment that's contemplated by the Consent to Treatment Act. If a physician wanted to treat someone in a home and it would definitely fall within the definition of consent to treatment, then you could have that implied

consent, that additional authority where the health practitioner has to seek consent to the treatment. But the authority in the Consent to Treatment Act for admission to the hospital or other facility is incidental to the treatment. That's not the primary concern in the long-term care facility.

On the point about the Human Rights Code, the issue came up yesterday about whether a home that has all women as residents could maintain that. I've done some research and found that section 20 of the Human Rights Code—I think it's probably still section 20, although it has been revised—states that the right under section 2 to equal treatment with respect to the occupancy of residential accommodation without discrimination because of sex is not infringed by discrimination on that ground where the occupancy of all the residential accommodation in the building, other than accommodation that's occupied by an owner or a family, is restricted to persons who are of the same sex. What this means is that you can have a home which is all one sex or the other, and it would be exempt from that.

Mrs Sullivan: That's fine. Thank you.

The Chair: Our next presenter is the Senior Citizens' Consumer Alliance for Long-Term Care Reform, but they may not be here yet.

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REGIONAL MUNICIPALITY OF NIAGARA

The Chair: I understand that the representatives from the regional municipality of Niagara are here. If you're prepared to come a little sooner, we would be delighted to have you come forward now, and we thank you for being here at an earlier hour. On behalf of the committee, I want to welcome you to our proceedings. If you would be good enough to introduce the members of your delegation, then please go ahead with your presentation.

Mr Brian Merrett: Thank you very much, Mr Chairman. It's a pleasure to be here this afternoon. The traffic wasn't too bad from Niagara, so we were able to get here a little earlier.

My name is Brian Merrett. I'm the chairman of the regional municipality of Niagara. On behalf of the regional council and our community and health services committee of the regional municipality of Niagara, I extend our appreciation for this opportunity to make this presentation regarding Bill 101 and other matters that relate to long-term care reform. Our presentation today will highlight the brief we've presented to you.

We treat this as a very serious matter. Accompanying me is Councillor Roy Adams on my far left, who is a former mayor of the city of St Catharines and chairman of our community and health services committee. We also have Doug Rapelje. Doug is the director of our senior citizens' department and probably known to many of you here.

We have been very much involved throughout the public consultation process, with Councillor Adams chairing Niagara's consultation advisory committee, and the director of the senior citizens' department, Mr Rapelje, also serving as a member. We commend the province on this process but suggest that many of the proposals being put

forward, including Bill 101, do not reflect what we heard in Niagara.

The regional municipality of Niagara, through its senior citizens' department, has a long and progressive history of providing quality long-term services to our seniors. We support many of the provincial initiatives proposed under the long-term care and support services in Ontario and we have a long-standing commitment to services for the elderly dating back to 1952. We have seen tremendous growth in these services but have great concerns that the proposed Bill 101 could have a serious impact and effect on that commitment.

The Niagara model, which has been widely recognized, embraces many of the principles that are proposed in the reform and we feel that our success supports these principles. Our model in Niagara offers a continuum of care. We have one point of entry, multidisciplinary assessments for institutional and community programs, with delivery through the following services funded both by the province and by the municipality:

In Niagara, we operate six homes for the aged with 919 beds: we have seven day care programs for the physically frail and cognitively impaired; we offer 16 satellite homes for seniors living with families in a supervised private home setting; home sharing, where our seniors share their homes with others; our vacation-respite care has 14 beds that provide short-term stay for family care givers, to provide relief for families in order that they can have a short break and vacation; we have our home help services where we provide homemaking, companion sitting, home maintenance, yard work and others; also our Alzheimer respite companion program, one that has been tremendously successful, where we have trained workers who relieve the care givers in their homes in the community; we have Talk a Bit, which is a telephone security program; we have friendly visiting, where we have trained volunteers who provide services to community-based elderly and the physically handicapped, and we have our senior volunteers in services, who use their skills and talents to help other seniors in the community.

We bring these services to your attention, as we believe long-term care reform can only be successful if a range of services is available that can respond to identified and real needs in the community. Based on the information we have received to date, we believe our model, which assures clients a continuum of care, is in jeopardy. What is proposed in Bill 101 and some other aspects of long-term care reform will prevent us from assuring clients a continuum of care, and this is the basis for the success of our programs in Niagara. Also, we would point out that non-profit homes for the aged and charitable institutions have been leaders in providing community programs.

As a major service provider in Niagara, we share the government's commitment to the four principles outlined in the government's discussion paper, Redirection of Long-Term Care and Support Services in Ontario.

However, we suggest that with Bill 101 the province has lost sight of some of these principles, the most important principle being, in our opinion, the quality of service. The bill focuses on provincial controls and penalties rather than quality and may jeopardize our ability to assure quality. Also, the province must realize that communities are at different service levels and have different priorities which must be considered as communities plan as partners with the province. It must be recognized that municipalities have provided leadership, management and delivery of long-term care, which Bill 101 seems to ignore. There seems to be an emphasis on the weakness in the system. We believe it is important to maintain the strengths within the system and enhance them. We believe that aspects of Bill 101 fail to recognize many of the present strengths.

Bill 101, we respectfully suggest, has many flaws and promotes an adversarial climate rather than a partnership between client, service provider and the province. We support the concerns expressed by the Ontario Association of Non-Profit Homes and Services for Seniors regarding Bill 101 in its January The Communique, "The message from Bill 101 to the non-profit sector is clearly that we are not to be trusted, that our boards are not capable of being accountable for their homes and that policing and punitive measures are the only ways of ensuring quality-of-life programs, fiscal accountability and appropriate care for residents."

Simply stated, this is not the way to foster strong partnerships, trust and cooperation.

What I would like to do now is turn over our presentation for some more detail to Councillor Adams.

Mr Roy Adams: Good afternoon. I welcome this opportunity because of my interest in social and health issues and my involvement in the long-term care consultation process. There are a number of key issues and I would like to highlight the key issues that are set out in more detail in our brief which must be considered and amended before the third and final reading of Bill 101, and which are governance, inspections and accountability, financial funding, placement and admissions and standards for long-term care facility programs and the service manual.

With regard to governance, Niagara is proud of its community involvement and public accountability in delivering services to seniors. We believe the present mandate of boards and committees of management in non-profit homes for the aged has the governance in proper hands. We had the first residents' council in a home for the aged in Ontario and we have adopted a residents' bill of rights and responsibilities. We acknowledge and support quality assurance programs, which have existed in our facilities and community programs in excess of four years. We are in the process of establishing community advisory committees in the homes for more public input and accountability.

The role of elected boards in municipalities in planning, managing and delivering long-term care is not acknowledged and in fact Bill 101 diminishes their role. We believe this has to be reconsidered.

Inspections and accountability: We welcome the efforts to increase accountability of facilities, recognizing, however, that many municipal long-term care facilities have many accountability measures already in place; there is a partial list in our brief.

We have very strong reservations about the inspection system proposed in Bill 101, which once existed in the homes for the aged. Over the past number of years, and particularly since the establishment of long-term care area offices, quality of care and services have benefited very much through a consultative process and a partnership with our program supervisors, more so than with the previous inspection system. This could be achieved in a more cost-effective way by using the mandate of the committees of management or the authority provided through your long-term care office. We believe accountability is best served at the municipal level.

We have greatly benefited through the consultation process applied in the accreditation program and we would strongly recommend that the province make accreditation mandatory.

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We believe the proposed inspection process suggests an authoritarian approach rather than the present system which allows the ministry and facilities to deal effectively with specific incidents and violations of non-compliance. Bill 101 appears to be authoritarian and adversarial rather than collaborative and consultative between responsible partners. The dollars that will go to inspections should be directed to funding the care needs of the residents, as it is our belief the proposed new funding system will fall short of the mark.

Addressing placements and admission: The proposed placement-admission system is costly, bureaucratic, authoritarian and adversarial. In many communities there is a partnership of facilities, referring agencies and placement coordination services which responds appropriately to consumer needs in a timely and compassionate manner as existing service levels allow. These partnerships should be supported and strengthened, not replaced. This would require strengthening of the resources and mandate of existing placement coordination services, but not with the authoritarian and adversarial system envisaged in the legislation.

In Niagara, we have currently a department-wide access and service coordination function that collaborates with consumers, families, PCS and referring agencies that we believe works well. The system must ensure a high degree of choice and control by the consumer. The proposed appeal system will be costly, bureaucratic and untimely given the age and changing needs of the consumers. Historically, we have received few complaints about admission refusals, but we do receive more complaints about the lack of available beds

We are concerned about the power of placement coordinators and their immunity from liability. It appears the placement coordinator has the vested power to act independently of both consumers and the facility. We would like to enhance the success of many of our community programs, which support the province's principle of helping maintain people in their homes or in the community, but success requires the guarantee of a continuum. We respectfully suggest that the admission process set out under Bill 101 fails to recognize or acknowledge this important factor.

Addressing finances and funding: At a recent meeting in Toronto sponsored by the Ontario Association of Non-Profit Homes and Services for Seniors, a provincial bureaucrat stated that the province has established a set amount of facility funding for the new system. We are concerned that the new funding is based on an additional \$200 million previously announced, yet this in itself could be restrictive if the system is to assure funding for real care needs.

We want to also bring to your attention the possible shortfalls in revenue if the government introduces the proposed restriction on the use of residents' assets towards the cost of their care and preferred accommodation. If this becomes a reality, we have analysed our over 900 residents and it would create an approximate annual shortfall of \$600,000. In addition, it appears we will no longer be able to make claims against estates, which we estimate will result in a further shortfall of \$200,000 in Niagara. If other constituencies have the same results, millions of dollars of revenue will be lost.

With regard to the new funding system that is proposed, it appears it is not driven by consumer need but rather by funds currently available. The region of Niagara, like most municipalities across the province, is clearly not in any position to make up funding shortfalls arising out of the new proposed funding system. We may face bed closures, and other measures may be required in order to match service levels with available funds. It is our belief that most citizens with means would prefer to pay a little more for care and preferred accommodation for the assurance of quality care. We need not remind the province, as we know in the municipality, that this is not a time to reduce revenue.

Regarding standards in long-term care facility program and service manual: It is acknowledged that considerable discussion has taken place involving the ministry representatives and representatives of service providers and advocacy groups. It is critical that further input be reserved from practitioners prior to implementation in order to clarify expectations and to assess the practicality of specific standards and criteria.

We can only assume that the province has considered the cost implications and will build in funding that allows us to meet the standards set out in the program and service manual.

To cite an example, although many of the criteria for dietary care are commendable in principle, their implications may not always be practical or appropriate for each resident. For example, "Residents requiring assistance are seated in upright position with head tilted slightly forward" may not be practical for some residents; similarly for dietitian hours and other staffing standards and related criteria which appear to be based on assumptions that may need re-examination or reconciliation with current acceptable standards of practice which produce equally acceptable services and care.

In conclusion, when we examine the four principles set out in the government's discussion paper, we would add one: quality and service. Bill 101 falls well short of the mark in supporting these principles. Bill 101, we respectfully suggest, has many flaws and promotes an adversarial climate rather than a partnership between the client, service providers and the province. Long-term care has been a long time coming and it is important that we get it right. We respectfully suggest that Bill 101 does little to achieve the right system and does not promote the right environment to work in these difficult times as partners.

We anticipate that you, Mr Chairman, and your committee, will reconsider Bill 101 and the negative effect it could have on reshaping long-term care in Ontario.

I thank you for the opportunity to be a part of presenting our brief. We would be pleased to answer any questions.

The Chair: Thank you very much for coming from Niagara today to make the presentation, both the two statements as well as the document you've also given to us. We'll move right to questions and begin with Mr O'Connor.

Mr O'Connor: Thank you for your presentation. I'm sure you can see that over the course of these committee hearings we've heard some changes, some differences of opinion and some areas of concern repeated. So, of course, some of that we take under advisement.

I noticed in your comment you talked about grand-parent action,intergenerational involvement, and I just wanted to tell you a little story about a grade 3 class from St Bernadette's in my riding. They go one Thursday or Wednesday a month for an afternoon; they spend the afternoon right in the nursing home. It's a terrific experience for not only the children but of course for the elderly there; they really do enjoy that. I think there are lots of models and different programs that take place throughout the province and it's always good that we can share whenever we can.

What you've talked about here—and it really does pique my interest—is the residents' council that you have. We heard in a presentation earlier this afternoon from the Advocacy Centre for the Elderly and they talked about the recommendation of enforcement mechanisms for the bill of rights and I just wondered if perhaps you might have an enforcement mechanism for your bill of rights because you do have a bill of rights—

Mr Merrett: I will refer that to our director to make a comment.

Mr Doug Rapelje: You might be interested to know that in one of our homes we have a fully licensed nursery school that operates, and those are the things that really make a tremendous difference.

With regard to our residents' councils, we basically have the residents' council to monitor that, but what we're finding as we care for more physically and mentally frail residents is that we are enhancing our residents' councils by adding a family member, a volunteer and a person from the community who has no connection with the home so that we can strengthen the role. We're all finding it more difficult in our facilities, particularly in four of our facilities—they're under 100 beds—to really get people who can truly speak and represent the concerns of the residents. Not only to assure that those rights are adhered to, we're

finding it necessary to enhance those councils by adding people who have an interest but can make sure the needs of the residents are properly expressed to us.

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Mr O'Connor: In your brief you talked about an adversarial nature, and I guess it's something we've heard before, because the word "inspector" just seems to be a focus. It's like a lightning rod. People are coming in and saying, "This inspector is going in there," and it's that adversarial approach. I just wondered if you might want to comment on the approach that you're talking about as an accountability and how that might interrelate with the total quality management perspective, because I think we don't want be heavy-handed; we want to try to improve on what we do have existing, where possible. I just wondered if you might be able to comment on that aspect.

Mr Rapelje: One of the either advantages or disadvantages—I've been in this field for 40 years. I should point out I started when I was 14.

Mr Owens: A couple of years ago.

Mr Rapelje: Yes. But I've been through the whole cycle of where we had inspectors in homes for the aged many years ago, and if I could offer a personal opinion, as we did in the brief, it's my judgement that the type of consultation process in working with our local ministry office, accreditation, and as you'll see in our briefs, the many various inspection groups from occupational health and safety, the panels—what do you call those, the inspection panels?

Interjection: Grand jury panels.

Mr Rapelje: Grand jury panels. I think we figure there's about 27 or 28 different groups coming in, and I guess my experience is that the consultation process results in a more positive outcome, and again, inspectors come and they leave. I think accountability has to be a continuous, ongoing process. It's the one advantage of the municipal homes. I'm sure some of you have been municipal politicians. If there's a complaint, I hear about it and we do something about it. We don't wait for an inspector to come from Toronto.

I base it on my experience of being involved in both approaches, and unquestionably, in my opinion, the other is much more effective and the outcome is much more worthwhile, the idea that accountability should be local through our politicians. I was surprised with the private nursing homes that some thought hadn't been given to having boards like hospitals that if the owner wanted to appoint three people or the ministry three people or police boards, like Roy and Brian are on, it wouldn't be a more effective way if you're looking for accountability. I just simply do not believe that inspections in themselves work as well as the other approach.

Mrs Yvonne O'Neill (Ottawa-Rideau): Thank you so much for coming, gentlemen. I am always happy when municipalities, and certainly the regional municipalities, come forward, because I think they are crucial partners and have been, and I am very pleased that you talked about the fact that there are existing strengths there today and

that they have to be built upon and they shouldn't be ignored and that the municipalities have taken a strong leadership role, and a strong leadership role in accountability, on the issues we're discussing.

You've brought forward three parts of your plan or your model that I'd like to ask you to say a little bit more about because I think they're interesting and have been parts of our discussion as we've gone across the province. First of all, if I may begin with the respite care, would you like to say a little bit about where and how you established those and just flesh that out a bit?

Mr Rapelje: Probably we were among the first to introduce respite beds. I think we've had a reputation, in working with people like Geoff and so on over the years, that we were always willing to stick our neck out. We had realized that many people were coming into our homes permanently who didn't need to be there, who had family care givers but the family and our whole system have never really recognized their role, and that if we could give them an opportunity for a break or a rest, they wouldn't burn out and they could continue. We started with one bed. We are now up to 14 beds.

We have different models. One is the straight respite program, where they can come in for a week up to a month. We have one that we just introduced particularly to deal with Alzheimer's victims, where they can book a year ahead and come in one week a month just so the family is always assured of a break and can look forward to it. We've just introduced night care because we've found that many care givers, particularly caring for the cognitively impaired, are up wandering around all night, so they couldn't get their sleep. They are admitted to our homes about three in the afternoon, they stay all night and now we are also allowing them to stay on day care if they want. So the family gets a whole 24 hours of rest.

Then, with our Alzheimer's respite program in the community, we hire and train workers who go into the homes of families caring for Alzheimer's victims for half a day or a day, again giving care givers the relief so that they can at least get away from that care-giving role.

They've been very successful, and I commend the government for identifying these as funded beds within our system. We just had to go ahead and do it. There was never any legislation nor were there really any funds, but basically I commend the government. I think those are the types of programs—if we are going to make this system work, if we're going to slow down the need for increasing institutional beds, then those services have to be in place.

I just want to suggest—I have the opportunity to travel to many parts of the country to talk about these things—that if these are not in place, and I suggest to you in many communities they aren't, when we talk about a continuum of care, it means nothing unless there are choices in the system that will allow people to move within a system as their care needs change.

Mrs O'Neill: Would you say a little bit about the community advisory committee that you have recently, I think you said, started up?

Mr Rapelje: Yes. We're just in the process now of looking at terms of reference.

Mrs O'Neill: Why did you feel you needed this? You seem to have such a responsive system. Could you just say a little bit about that?

Mr Rapelje: Exploring it at the moment—Ottawa has them, and there are a few other communities—was just another way of allowing the public to have some input into the operations, support us in fund-raising. I think things are changing to where we're doing things differently and looking for different sources of money. So it really was to have an outside body that did not have any political involvement with the home, to be able to have input and to work with the administrator of that home and to report once a year to the community and health services committee which Councillor Adams chairs.

Mrs O'Neill: Do you think they should be mandated in Bill 101?

Mr Rapelje: I think what I would suggest is that we need some experience to see how well they do work. I think in principle they have a lot of merit, but I would suggest that if we could get three or four municipalities and then evaluate them, it might be better to make sure they are effective and that they aren't at cross-purposes with our committees of management and so on.

Mr Merrett: If I could just add to that, as far as we're concerned in Niagara, even though we are one united region on most things—I say that with tongue in cheek—our six homes are in different communities and are different sizes, and those communities have a different relationship with the home in their area. There's that identity with that community, besides it being a regional home, and this gives an opportunity to tap into what's in that community. There are some that have resources available that others don't. That's what gives us an opportunity to broaden our base in the community and have access to the resources in that community.

The Chair: Thank you. Mr Jackson.

Mr Jackson: Both regional chairman Merrett and Councillor Adams: To what extent have the discussions on disentanglement raised or come close to raising the issues around the offloading of these additional expenses to the regional government?

Mr Merrett: Overall, as far as disentanglement goes, and with the recent announcement, we are examining the financial impacts on the region of Niagara. I've personally been involved, through the regional chairmen's group and others, in the whole discussion, but we are developing our position right now and looking at the cost to Niagara.

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Mr Jackson: Could you expand on that for us? Are you talking about the general disentanglement discussions, or the disentanglement discussions around social service funding envelopes and as it relates specifically to the additional costs you will be called upon to pick up as a result of this legislation? Have there been any discussions to date, or are you simply preparing your position to inform

the government of probably what it already knows about the implications of this legislation on regional taxpayers?

Mr Merrett: Doug, maybe you want to comment as far as some of the information you've been putting together is concerned.

Mr Rapelje: Do you mean with this bill particularly, or the disentanglement with welfare and other aspects?

Mr Jackson: I don't want to get into the details of disentanglement and welfare. Specifically in social services, there have been preliminary discussions about the broad range of issues, from day care to doughnuts. Have you had specific discussions about homes-for-the-aged funding, capital or operational, and/or the implications of this bill, which will have financial impacts on your having to pick up additional costs?

There's disentanglement through consultation, and then there is disentanglement through fiat, and what we're dealing with is disentanglement through fiat. The government is capping its contribution to extended care, but clearly you must read through this and find that you're picking up the shortfall. You're the one who's throwing \$200-million figures around, and so on. Clearly, it's implicit that you as the regional chair, and Councillor Adams as the chair of—what's your committee, Councillor? Sorry.

Mr Adams: Community and health services.

Mr Jackson: Clearly, you've seen the implications, so why is the government moving unilaterally when we're told disentanglement is on the table? I can assure you that I've been part of discussions with the former government around these capital and operating costs when disentanglement was being discussed with that government. Here now we've got a new government and it's floating out there to the public all the wonderful things we're doing on disentanglement and discussions, but frankly, this is happening whether you want to be consulted or not.

Do you understand clearly the focus of my question? Because this is a great opportunity, to have the regional chair here, and the chair of your health and social services committee.

Mr Rapelje: I think basically what we tried to bring out in our study, Mr Jackson, was our concerns, such as the commonly bandied-around average being \$90 for homes for the aged. If that happens in Niagara, we will have about a \$1-million to \$1.5-million shortfall. We're very concerned and I must say, with all due respect to the civil servants who try to come to our meetings and answer questions, like the one I was at two weeks ago, what concerns me greatly is that we're trying to evaluate the overall picture but we're doing it like we normally do, in little pieces.

It seems to me that unless you look at the whole continuum of care, this act, for instance—and more to your question—changes it where we may not be able to make charges that we do now. I have no problem with that as long as someone assures us that it won't end up on the backs of our residents receiving inferior care. Because it seems to me that even just in Niagara, if we can no longer claim on estates, that's \$200,000 in Niagara.

Mr Jackson: Let me interrupt you there because that begs the point. You're in the driver's seat now. We have removed this as an insured service under OHIP; this is going to be removed as a result of this bill. So it's no longer the universality of extended care under OHIP. It is now a contract with the state.

You're a level of government. We've disentangled. We passed it on down to your level of government, and you now decide what level of care—

Mr Owens: We need a response to this. I am alarmed.

Mr Jackson: Is Mr Owens rattling again?

The Chair: Order, Mr Owens. You are out of order. Mr Jackson has the floor.

Mr Merrett: If I could just make a couple of comments on the question that's been asked by Mr Jackson, in framing it, we're here to talk about Bill 101 and how it fits in in the whole disentanglement process, and the downloading of costs the region is feeling. I wouldn't know where to start today if I wanted to talk about downloading of costs such as Ministry of the Environment subsidies that we haven't received and the discussions we're having on disentanglement with roadways and assessment and trying to determine what 100% of welfare is. But that's another subject and I could spend some time on that.

We're here today to talk about bill 101 and the downloading of those costs and the quality of service we want to provide in Niagara. I can appreciate the government's need to examine this whole question and the type of service that's delivered throughout all of the province of Ontario. We're here today to tell you that in Niagara we do a damned good job and we've been studied and we are a model for not only the province, but the country. We've received international recognition on how we deliver our services. We've been able to handle the cost side of it.

As you know, we're all under tremendous financial constraints in our budget process and we've been able the last two years to maintain our costs and still provide a quality level of service. I guess we're here to say to you today that we feel we have something to contribute and offer in the delivery of long-term care in Ontario.

The Chair: Thank you for coming today. I should also just underline that it was a pleasure a couple of years ago to visit two of your facilities, one on Niagara-on-the-Lake, which is—

Mr Merrett: Gilmore Lodge in Fort Erie and Upper Canada Lodge in Niagara-on-the-Lake.

The Chair: That's right, both of which were state of the art; in particular, I remember—I think it was your day centre in St Catharines, which was built sort of like a tepee, if I recall. It was a marvellous structure and just the whole sort of architecture of it in terms of what you were trying to achieve struck me as very innovative. I think you have a great deal to be proud of in terms of what you've accomplished there and we're very grateful that you came here today and made your presentation.

Mr Rapelje: Mr Chairman, would you have just one minute for one very important issue that I don't want to be lost? We've spent 30 years putting together a continuum of

care and I want to suggest to you that if you look at this piece of legislation or any other in isolation, this does nothing to enhance a continuum of care.

If I might tell you, our satellite homes are some 22. The province has no capital funding and it has saved millions of dollars offering a choice. These are just ordinary families that take in people into their homes. If they have a health breakdown and I can't guarantee them a bed in one of our homes, that program is gone.

When you look at day care, if you cannot assure that daughter that it will be a continuum, that one day when they can no longer come in for day care they're just out on a waiting list with, in our case, 1,300 other people—I really caution you to not look at just Bill 101 but to look at, if you really believe—and that's what the documentation suggests—in a continuum of care, then the present restrictions in Bill 101 would prevent me from transferring people within our system. It really affects how people behave in a system. A daughter will gladly tolerate her mother being on day care for 10 years as long as she knows that the day her health breaks down there will be a bed, not be told, "I'm sorry, you're no longer eligible for day care; you go on a waiting list."

I want to just leave that with you to think about because when we look at this piecemeal—I've been through this too many times—we're going to end up with a fragmented system the same as we've always had. What people are looking for, in my opinion, is the assurance that mother can start out on Meals on Wheels and, if necessary, get care in a good, long-term care facility, often with a lot of stops in between. Thank you, Mr Chair.

The Chair: Thank you all again for coming to the committee today.

Mr Adams: I have another comment, but I'll spare you it.

The Chair: Oh no, please.

Mr Adams: As chairman of the redirection of long-term care committee, we travelled around, and what was being forecast in that proposal is completely different than what it looks like it's going to end up being. I think we fooled a lot of people for a long time and I don't like to fool anybody.

Mr Merrett: Mr Chairman, again, thank you for the opportunity to be here. Members, thank you for your attention.

The Chair: Thank you.

1540

SENIOR CITIZENS' CONSUMER ALLIANCE FOR LONG-TERM CARE REFORM

The Chair: Perhaps I could now call on the Senior Citizens' Consumer Alliance, which is with us, if they would be good enough to come forward.

Mrs Jane Leitch: We apologize. We misunderstood. We understood we were to be here at 3:30, so we apologize for that.

The Chair: It's quite all right. It worked out fine. Other delegations were here, so no problem; we're just glad we have you before us now and we have received a copy of your brief. Just before asking them to introduce

themselves, I would tell members of the committee that they've also given us two copies of the Consumer Report on Long-Term Care. Foe members who would like to look at that, we can arrange to do that.

Mr Jackson: Mr Chairman, I wonder if may ask legislative research to provide Mr Owens with a copy of legal counsel's confirmation that in fact extended care is being delisted by his government. If they could just make that available from the Hansard to Mr Owens, who perhaps had to be out of the room for a moment when that question was raised earlier today, that might resolve his penchant for interruption.

The Chair: Parliamentary assistant.

Mr Wessenger: I'm going to ask legal counsel to clarify that point.

Ms Czukar: Extended care is offered in nursing homes. The payments that are made to homes for the aged, both charitable and municipal, are not insured and never have been insured services under the Health Insurance Act. It's only the extended care payments made to nursing homes.

Mr Owens: So what's being delisted?

Mr Jackson: So nursing home extended care is being delisted by the NDP government?

Ms Czukar: It will be removed from the regulations under the Health Insurance Act, which will have the effect of de-insuring it, as is done now in 8 out of 10 Canadian provinces.

Mr Jackson: That's what I heard. Thank you.

The Chair: Thank you. I want to-

Mr Owens: You heard what you wanted to hear.

The Chair: Order, please. I want to just note again that if any member wishes to look at this, we have two copies and they can be made available.

Welcome to the committee, and perhaps you would be good enough to introduce yourselves and then please go ahead with your presentation.

Mrs Leitch: Thank you very much. I'm Jane Leitch, chairperson of the Senior Citizens' Consumer Alliance for Long-Term Care Reform, and with me is Beatrix Robinow, one of our members.

The alliance is made up of three organizations of the largest consumer groups in the province: The Consumers' Association of Canada, Ontario division, the Ontario Coalition of Senior Citizens' Organizations and the United Senior Citizens of Ontario, and collectively we speak for approximately 1 million seniors.

Over the past 21 months the alliance has been examining the evolving government policies on long-term care reform, speaking with some of the best policy experts in the country, listening to what service providers have to say and speaking among ourselves as consumers and as taxpayers.

Through this process, the alliance learned that Ontario has a rich array of health and social services and facilities that are tremendously fragmented. As a result, the task of coordinating care to meet people's needs can present real barriers to accessibility.

In our Consumer Report on Long-Term Care released last July, the document Mr Beer is speaking of, our panel made a number of recommendations to better link Ontario's long-term care services into a seamless continuum. This kind of coordination is essential if consumers are going to easily access the care they need when and where they need it.

Given the emphasis that our alliance placed on better system-wide coordination, we are extremely concerned that Bill 101 is being put forward and debated in isolation. The reform of long-term care facilities is only one part of a much larger reform initiative including community-based care, supportive housing, health promotion and rehabilitation programs, chronic care and palliative care.

We understand that the government intends to release its broad implementation framework for long-term care reform at the end of this month. Without the context of this broader framework, the alliance cannot fully endorse Bill 101. Therefore, we recommend that Bill 101 be revised so that it is consistent with the overall long-term care framework. In particular, the revisions must encourage linkages between all aspects of the long-term care system to ensure consumers a seamless continuum of service.

In addition to this overriding concern, the alliance would like to share our thoughts about specific elements of Bill 101. We'd like to begin by focusing on the positive parts.

The alliance is pleased that Bill 101 will treat nursing homes, charitable homes and homes for the aged equally, under a single piece of legislation. Some of the current problems with these facilities stem from the fact that each is governed by separate pieces of legislation sponsored by different ministers.

We also support this bill's efforts to create clearer lines of accountability. In particular, the requirements that facilities must share and explain a resident's care plan with him or her is a welcome one. This ensures that expectations are clear and that consumers and their families have a basis for assessing the quality of care they receive.

The requirement for facilities to post service agreements and financial statements is another step towards improving accountability for consumers and their families. Posting such information is important for consumers when selecting a long-term care facility.

We support this bill's effort to better monitor and enforce the actual provision of funded services by withholding or recovering funds for services that are not provided. While we have some concern about the consequences of these sanctions, we commend the intent to create a more accountable system of facility care in Ontario.

The provisions for allowing regulations to designate beds for specific purposes such as short stay or respite is another positive aspect of this legislation. Throughout our hearings the alliance heard from family care givers who need access to respite services. While many would prefer in-home care, no doubt facility-based respite care would be welcomed.

We are pleased to see provisions for facilities to provide and govern in-service training programs for facility staff. In future, as community-based services expand and

the size of Ontario's elderly population grows, the clientele of our long-term care facilities is expected to be more fragile and indeed of more complex care. These demands will require ongoing training for the staff in our facilities and we're pleased that this need is being recognized.

Now we'd like to spend a few minutes and talk about the highlights of some of the alliance's concerns.

There's too much left to be defined. There are a number of areas where the alliance has real concern about this legislation. Our future concern is that too many important issues are left to be defined in regulations. For example, the bill allows regulations to be developed to govern charges for certain services. We're concerned that, as written, this provision allows the possibility that consumers may one day be asked to pay user fees for personal care services. The alliance fundamentally opposes such fees and believes the government shares our view. Bill 101 should be revised to clearly state that resident charges will not be permitted for nursing or personal care services offered within a long-term care facility.

Also, Bill 101 allows regulations to come into effect retroactively. As consumers, we find such a provision odd. If such clauses were applied to residents' care, for example, it could create real hardships for consumers. We'd like an explanation of why this provision is necessary and recommend that the clause permitting regulations to come into effect retroactively be removed.

While the alliance supports the introduction of service agreements as outlined in the legislation, we know that how these agreements are defined will determine their effectiveness. We appreciate that service plans must be flexible enough to meet the unique needs of each facility. However, we also believe that provincial standards and guidelines, developed in partnership with providers, consumers and facility workers, are needed to ensure a consistent level of care throughout Ontario. Therefore, we recommend that provincial guidelines and standards be established for the development of facility care agreements and that the regulation governing service agreements must reflect these provincial standards and guidelines.

It is our understanding that although the basis for provincial funding will be the same regardless of the type of long-term care facility, the actual amount received will depend on the level of nursing care required by residents. Quality-of-life programming, such as rehabilitation, recreation and spiritual care, is expected to be funded separately under another, as yet unknown, formula.

Although this issue is not dealt with in the proposed bill, we're worried that this approach, borrowed from Alberta, will eliminate any incentive for rehabilitation or quality-of-life programming. Such facilities would receive less money as the residents improve.

1550

This is exactly what happened in Illinois when the department of public aid paid its nursing homes according to the level of care provided. While the goal of this policy was to keep the elderly as independent as possible, when analysts actually reviewed the results they were horrified to learn that the percentage of residents who were bedridden was increased steadily.

By paying more for bedridden patients, Illinois had inadvertently given facilities a financial disincentive to get their residents up, involve them in activities and help them function individually. As David Osborne and Ted Gaebler point out in their book Reinventing Government, "Because the funding formula focused on input but ignored outcome, it had produced the exact opposite to the state's intentions"

This situation was corrected when the state began focusing on program measurements such as consumer satisfaction, community and family participation and the quality of nursing home environment. Now each institution is visited periodically and rated by a group of nurse managers. The higher a nursing home is rated, the higher it is reimbursed. For example, the six-star rating is worth \$100,000 a year more than one-star rating. These ratings are also published and shared with the public so that the consumers can be able to choose a facility based on its quality.

To address our concerns we recommend that Bill 101 be amended to mandate annual consumer, family and worker satisfaction surveys. The outcome of these surveys should be rated and published and facilities should be rewarded according to the rating.

As well as providing an important balance to government's proposed funding for facilities, the alliance believes that annual consumer, family and worker satisfaction surveys are also important. They are ways to improve the approach to quality of care outlined in Bill 101.

Concerns about quality of care in Ontario's long-term care facilities have been documented in a number of reports. For example, in a brief submitted to our alliance Concerned Friends of Ontario Citizens in Care Facilities concluded that 146 of Ontario's 263 nursing homes had serious violations. Similarly, the 1990 Provincial Auditor's report recommended that efforts to monitor quality in homes for the aged needed improvement.

The bill requires each facility to have a quality assurance plan which outlines how quality will be monitored within the facility. However, there's no mention that deficiencies in quality, when identified, must be improved.

While Bill 101 has strengthened government's inspection powers and enhanced its ability to enforce compliance by withholding or reducing funds, the alliance believes this will not provide an effective means of assuring quality. For one thing, facilities are given advance warning of an inspection visit so they're able to tidy things up for that occasion. This kind of behaviour does little to improve the quality of life for consumers living in this facility year-round.

The alliance would prefer to see Bill 101 outline a different approach to quality. Our approach would see inspection and enforcement as only part of a much broader, more systemic effort towards quality improvement. This approach would include a comprehensive program involving standards, measurements, comparisons, remedial action plans, reassessments and incentives to encourage full participation by all staff in continuous quality improvement.

The program would place less emphasis on punishing poor quality and more emphasis on rewarding high quality. While we recognize the need for punitive measures, the

alliance believes that if they are the only means of ensuring quality, the result will be a system which operates in fear and hides problems rather than solves them. We don't believe this is an ideal environment for anyone to live in.

The focus should be on residents' outcome, not just inputs. For example, during our public hearings, the alliance was shocked to view slides on the average mouths of residents in facilities. Basic oral hygiene of residents was obviously not being seen to, but we were told that the staff routinely check off having cleaned residents' teeth and dentures even when they hadn't. Rather than relying on completed forms, the health of residents' mouths should be used to assess quality of care.

We understand that some of the Ontario long-term care facilities already voluntarily participate in a national accreditation program offered by the Canadian Council on Health Facilities Accreditation. This program could provide an important source for comparisons between and among long-term care facilities. In addition, a comprehensive quality improvement program may be developed affordably by building on the expertise of the CCHFA's program.

To improve the quality of Ontario's long-term care facilities, our alliance therefore recommends that the approach to quality adopted within this legislation be broadened beyond inspection and enforcement to include the measurement of residents' health outcomes and an emphasis on rewarding facilities for higher quality care, and that residents' councils be required in all long-term care facilities to provide important insight into specific quality concerns.

We are very concerned about the sweeping powers of the placementcoordinator as outlined in this legislation. While the government has stated a strong commitment to consumer choice and empowerment, Bill 101 identifies the placement coordinator as the sole authority for determining eligibility for facility care and the sole authority for determining an individual's particular placement.

We see no room in this model for consumers' choice or any sensitivity to consumers' ethnic, cultural or religious needs. And, while many consumers still rely on their family physician to oversee placement, it appears the family physician will have no authority over these decisions in the future.

According to the bill, each home shall have a designated placement coordinator. We're extremely concerned that this legislation creates a situation where placement coordination will occur in isolation and decisions will be made on the basis of paper review only. The legislation is also unclear about what will become of Ontario's existing placement coordination services. These organizations have a wealth of expertise that should be built upon.

In our Consumer Report on Long-Term Care Reform, the alliance recommended that placement coordination occur within the community-based, comprehensive multicare service organizations. Where they exist, the alliance hoped that placement coordination agencies would come together with other community agencies to form the CMSOs. For consumers, such an approach would ensure continuity of care since their CMSOs would already be

familiar with their needs and therefore best able to help assess their alternatives, and, to foster coordination between community-based care and facilities, our alliance recommended that representatives from long-term care facilities participate in developing protocol for entry into facilities and be guaranteed placement on local CMSO boards.

In keeping with the recommendations contained within our Consumer Report on Long-term Care, the alliance recommends that Bill 101 be amended so that placement coordination is not solely the responsibility of the placement coordinator but rather is the function of community agencies in partnership with consumers and their families.

The appeal mechanism outlined in this bill for individuals wishing to challenge the decision of a placement coordinator offers little comfort to consumers. With a single health appeal board, we're afraid that the wait for a hearing could become very lengthy. For consumers in need of facility care, time is of the essence. Appeals need to be provided quickly and efficiently and as close to the consumer's home as possible.

Therefore, as an alternative our alliance recommends that Bill 101 be amended to establish an arm's-length appeal board within each district health council. These boards should include consumer representatives.

The alliance is concerned about what resources will be made available to consumers when making an appeal, and finally, we find the appeal board's quorum of one person utterly ridiculous. Bill 101 should be amended so that the quorum of an appeal board contains at least two people.

As consumers, one of the most disturbing elements of Bill 101 is that it allows regulations to establish the frequency of reapplication for placement. Not only does this undermine consumer choice but it also overlooks the fact that people's health status or situation can change suddenly. The alliance does not believe that arbitrary limits can or should be imposed on reapplication.

We therefore recommend that references to regulations which will limit the frequency of reapplying for admission for long-term care facilities be eliminated.

There's a summary of the recommendations at the end, but at this time Beatrix and I would be open for any questions. Thank you.

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The Chair: Thank you very much for a very full brief and for the recommendations. I know there are questions and we'll move to them right away, beginning with Mrs Fawcett.

Mrs Fawcett: Thank you very much for coming before the committee today. I know you have done so much work in this area before the actual bill came forward, and obviously you continue to provide us with some good thought.

I was interested in your "Proposed funding formula for facilities may eliminate incentive for rehabilitation," and that section. It seemed as though you were coming up with the idea of possibly focusing on the positive outcomes rather than what the bill seems to be suggesting in the way the funding formula that will provide the funds for the

levels of care. At the bottom of page 4 it said that, "This situation was corrected when the state began focusing on performance measures such as consumer satisfaction." Certainly that is worth considering.

Then you talked about quality assurance plans and the idea of inspections. We've heard a lot that the idea of inspectors and inspections is rather a punitive, negative idea and that possibly we should be looking at quality management plans and then also focusing on a more positive approach so that all of the facilities would be measuring up but because of the positive things. I wondered if you would like to comment on those two sections.

Mrs Beatrix Robinow: You were interested in hearing about more positive things.

Mrs Fawcett: Yes. Many of the presenters who have come before us have been very worried about the quality assurance and the inspection idea as being punishment, rather than quality management and everyone working together for a more positive quality improvement in the actual facility and a better quality of care than would be produced.

Mrs Robinow: Yes, but that is exactly the one thing we were saying. We've heard the most dreadful horror stories about what goes on—

Mrs Fawcett: I think we all have.

Mrs Robinow: —and the kind of behaviour that people go into when they get warning of an inspection; everything is tidied up and it regresses immediately afterwards. That is something we're trying very hard to circumvent, to avoid again.

Mrs Fawcett: Right.

Mrs Robinow: We also feel that so many of these stories about nursing homes, and they have given us pause, can possibly be helped by some of the other things which were suggested, and particularly for the residents' councils, that the people who are being served, the people in the nursing homes, in the long-term care facilities have a say, should be able to say what they think without fear of retribution. What happens so often is that some poor elderly person is so scared of what is going to happen when their visitors leave again that they ask them, "Please don't say anything about the condition you've found me in, because I have to stay here and these care givers will take it out on me if this happens." So residents' councils and outside interests and community boards are, we think, the way to try to help this.

Mrs Fawcett: You would be in favour, then, of maybe mandatory residents' councils?

Mrs Robinow: Yes, every facility should have a residents' council.

Mrs Fawcett: You would like to see that in the bill?

Mrs Robinow: And residents' councils would be in the facility itself and possibly have also community representatives.

Mrs Fawcett: Community representatives on the—

Mrs Robinow: On the residents' council or, as we have suggested, that there also be consumer councils attached to such places.

The Chair: I'm sorry; I'm going to have to keep everybody to just two questions. Mr Wilson?

Mr Jim Wilson: Thank you very much for your presentation. I think you've done a super job, as usual. I know you've had a lot of experience appearing before legislative committees and doing briefs such as the one you've presented today.

There are a couple of things, though, I want to point out. On page 2 you talk about one of the positive aspects of the bill being that it brings together separate pieces of legislation. Don't be fooled just because it's one booklet. It still deals with several pieces of legislation with various ministries. So while it makes some improvement, it certainly doesn't go all the way.

I want to leave a question for the parliamentary assistant to come back to at his time regarding staff training. On page 3 they make a statement that the bill provides for facilities to provide and govern in-service training programs, and I'm just not aware of those aspects of the bill if they exist.

I want to ask the witnesses: In terms of funding, you've made emphasis in your remarks that you believe the government is, I suppose, on the right track in that it's only charging for basic accommodation and not charging for nursing services etc. But I'm just wondering, do you realize it's a shell game, that it doesn't matter whether you're paying for basic accommodation or nursing services or whatever? The user fee is money that goes to the home, goes into the pot and is part of money that is used to keen the consumer in the home.

The reason I mention it is that I find it ironic that this government's bringing in \$150 million worth of user fees. We were the party that talked about this in the last election, talked about where user fees should be appropriately placed. I have vivid memories of September 1990 when NDP candidates said they would never do this. Now I think that what they've done is they've put a spin on user fees. They've said it's for accommodations only and you'd pay that if you were at home anyway. It's bogus no matter which way you cut this argument. I'm just wondering if there was any frank discussion about that among the ONs.

Mrs Leitch: You're doing a very good job of defending it for us.

Mr Jim Wilson: Thanks, Jane, because I just want to make sure that the public's aware of that, and let's not be fooled again when politicians tell you about user fees.

Mrs Leitch: I think when you become a senior citizen, you become pretty suspicious of everything that happens and you try to look at the bottom line. We have tried very hard to see some positives in this bill as well as some of the negatives.

Mr Jim Wilson: Well, I guess I'm in opposition and I'll say facetiously that I appreciate you trying to find the positives, but—

Mrs Leitch: I think we specified our negatives as well, sir.

Mr Jim Wilson: Yes, and I appreciate that. In one of those that you sort of touch on—and it's a question, really, to the parliamentary assistant—when you're talking about limited applications for placement, and I think you make some excellent points there, I'm wondering what happens if a consumer turns down a placement coordinator. Is the consumer left on the placement coordinator's list? For instance, the placement coordinator says, "You have to go to X, Y or Z home," and say you absolutely refuse. Do you drop off the list or do you get to apply again? How does that work?

The Chair: Parliamentary assistant?

Mr.Jim Wilson: You can apply indefinitely?

Mr Wessenger: I'd like to answer that. The placement coordinator puts the choices in front of the consumer. The consumer makes the choices, and they make a first choice, a second choice, a third choice or whatever number they wish to make for a facility. Then the placement coordinator determines the question of priorities, because people having high priorities, greatest need, will get the first opportunities at vacancies at their choices. When a vacancy comes up at one of the consumers' choices, obviously that vacancy will be offered to the consumer. It could be number one choice; it could be number two choice. They'd say: "We now have a vacancy at such and such a place. Do you wish to accept that placement?" It's purely a question of putting the choices before the consumer. The consumer makes the choice.

Mr Jim Wilson: Okay. So what you're saying is that if the consumer says, "No, I don't like these three choices. I'll wait for the next round," the consumer can do that indefinitely?

Mr Wessenger: Of course he can do that.

Mr Jim Wilson: Then why do we have the worry in this brief that there may be a limit placed on applications?

Mr Wessenger: I think what is being referred to is the time frame, the fact that there's an indication in the brief that in the regulations you can put a limit that you can only make an application, say, every three months or six months. That, of course, would be subject to material change of circumstances. Obviously, you wouldn't have any regulation providing for a limitation without providing for a material change of circumstances.

Mr Jim Wilson: Well, that's not the way it reads.

Mrs Leitch: I think we'd like to respond to that. One of the things more seniors are worried about than any other single issue on this bill, as far as I'm concerned, is the control, the authority that the placement coordination person will have, with only one person deciding what your options are. Sometimes if you could stay at home but you need a lot of services, they'll say you can't stay at home and you have to go into a facility. That worries us a great deal.

The Chair: I'm sorry. We're going to have to move on, as time is passing. Mr Owens.

Mr Owens: I'm pleased that you talked about your association with Concerned Friends of Ontario Citizens in

Canadian Facilities. Freda Hannah, myself and a number of her colleagues have worked on some projects within my own riding, so I have a clear understanding of some of the issues that this group undertakes to investigate and advocate on behalf of seniors in this province.

I think that in terms of some of the language that's used in this bill, the words "quality assurance" cause me some difficulty. I think it's a buzzphrase and doesn't particularly have much meaning. You talked about oral hygiene and I think that is a really good example that one can draft care plans, but in terms of the actual efficacy of the care plans and the assurance that somebody's actually carrying them out, that is really the litmus test, in my view. How does one go about doing that?

Mrs Leitch: I would suggest that there be regulations but that the regulations be applicable a lot more often. I think the issue of being assessed once a year was the one that we were getting into here. Your case management would be assessed, and our health situation changes rapidly. We think there should be an ongoing monitoring of the services that are provided to us.

Mr Owens: I think the issue with respect to accreditation and relying on accreditation as an assurance of quality makes me a little bit nervous as well. I think the parliamentary assistant and legal counsel have indicated that while some residences in fact were accredited, they were on the other end of the process of pulling their licences to operate. So I'm a little bit nervous about relying on the accreditation.

Mrs Leitch: That's why we want consumers on the accreditation boards.

Mr Owens: Exactly.

The Chair: Final question.

Mr Owens: In terms of the inspection process, and given the conversation we've had on this point on these issues then, I have to gently disagree with your view, then, that the inspection process needs to be a little bit friendlier. I guess maybe I'm paraphrasing your language, but I think that given some of the episodes we've witnessed in terms of media, and again with my association through Concerned Friends, when I look at this language there is nothing coercive about this language if a residence is doing as it should be doing and working with the residents and families.

Mrs Leitch: I'm not sure what kind of a response you want on that. We would like to strengthen the appeal process, that's for sure. Did you want to add anything?

Mrs Robinow: I think mostly that it's important that we look at outcomes, what really happens; and not just what's going on in there but what the result is and how people progress.

Mr Owens: And having a process in place.

The Chair: Thank you. I'm afraid we're going to have to move on. There was one other question that I didn't let the parliamentary assistant refer to. It was the one regarding staff training.

Mr Wessenger: I think I'll ask Mr Quirt to just indicate again the funding situation with respect to in-service training programs.

Mr Quirt: Thank you. Bill 101 contains a change to legislation that allows the province to specify the type of training that might be required in a particular facility, and secondly, the intention is to allow training as a subsidizable expense in any of the three budget categories that funding will be flowed through to each long-term care facility.

The Chair: I want to thank you both again for coming before the committee and for the material you've left with

Mrs Leitch: Thank you very much.

VILLA COLOMBO HOMES FOR THE AGED INC

The Chair: I would like to then call the next witness, the representatives from the Villa Colombo Homes for the Aged, if they would be good enough to come forward.

Could I just indicate to committee members that following this presentation we will be having the presentation from the Bob Rumball Centre for the Deaf. In order to get organized for that, I will call a brief recess, as there are a few things that will need to be taken care of before that presentation begins.

Welcome to the committee. I know some of you have been sitting and listening to the proceedings. We appreciate your patience but we're delighted to have you. If you would be good enough to introduce the members of your delegation, then please proceed with your presentation.

Mr John Capo: My name is John Capo. I'm the president of Villa Colombo. Sitting with me at the table is Mr George Glover, who is the administrator of Villa Colombo, and Virginia Ariemma, who is the community development advisor for the Italian Canadian Benevolent Corp.

Honourable Chair and honourable committee members, it is a privilege for me to represent Villa Colombo and the Italian Canadian Benevolent Corp before the standing committee on social development at these hearings relating to the proposed passage of Bill 101.

There are several people with me today in support of our position on Bill 101. They are Mrs Colly Cavaluzzo, who is a former president of the Villa Colombo Ladies' Auxiliary and our governor of our board, together with other members of the Villa Colombo Ladies' Auxiliary; Mr Luigi Ferrara, a board member; Dr Annamarie Castrilli, former national president of the National Congress of Italian Canadians; Mr Manlio d'Ambrosio, president of the National Congress of Italian Canadians, Ontario; Mr Pal DiIulio, executive director of the Italian Canadian Benevolent Corp; and Mr Paul Pellegrini, president of the board of directors of Columbus Centre.

As you undoubtedly know, the Italian Canadian community is the largest ethnocultural group in Ontario and in greater Metropolitan Toronto. The Ontario Human Rights Code recognizes the inherent dignity and the equal and inalienable rights of all members of the human family. There are currently more than 70,000 seniors in Metro Toronto whose mother tongue is Italian, a number larger than the total population of many cities in Ontario, such as Barrie, Kingston or Peterborough. Many of these seniors are unable to adequately communicate in English. No senior can truly live with dignity if that senior cannot com-

municate needs in a language which he or she understands. Our moral obligation lies in representing the best interests of the seniors in our community, particularly those who do not communicate well in English.

Villa Colombo is the only non-profit extended care facility with a culturally sensitive focus for Italian-Canadian seniors. The majority of Villa Colombo residents are of Italian origin. The community investment in this home for the aged is priceless. Countless hours were and are volunteered to see that this home and lifestyle became and continues to be a reality.

Honourable members, we understand that part of the purpose of Bill 101 is to ensure standards of nursing and personal care for all people receiving extended care, whether in a for-profit or non-profit home. We of course agree with this principle.

However, we have many concerns regarding other aspects of Bill 101. I would be remiss if I did not take this opportunity to address uncertainties which relate to long-term care redirection and funding.

Since the early 1970s, Villa Colombo has had a three-way partnership in caring for seniors involving the seniors and their families, the community and the government of Ontario. We support a functional system which is responsive to needs in cooperative partnership with provincial standards.

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Bill 101, in its present form, appears to usurp not only the community's investment but also the function of directors, who are required by legislation to manage or supervise management of the business and affairs of a corporation.

Rumours abound, creating uncertainties and questions regarding major considerations such as: What happened to the January announcements on funding and chronic care? Were user fees calculated correctly in government estimates? Is it true that increased inspection will be done without additional inspectors, leaving for-profit homes, where scrutiny should be greater, open to fewer inspections? Is the means testing for user fees at a level which would disqualify most seniors? Can distinct cultural and urban needs be protected under the proposed legislation? How will unions be dealt with if the case mix indexes lower staff needs. How can the standards of care be met if funding is insufficient? Is there a future basis for partner-ship between the government and the community-based groups?

We are in a sense working in a vacuum. Through Bill 101, we are asked to accept legislation governing a system which is not defined. In addition, the proposed legislation seems in many respects to be contrary to the results of consultations. As stated by the chairman of the Niagara region just a brief while ago, Bill 101 has clearly not taken grass-roots involvement into consideration. While government has a major stake in the financial demands of future long-term care, so do seniors and so do community groups.

It is our preference that the process of legislation be delayed until such time as the governing system and standards are fully developed. We support changes in legislative acts, rather than in regulations, to ensure that the principles of community interest based groups are protected for the benefit of the citizens of Ontario.

We refer you to our brief, where we present our concerns on the legislation and have made suggestions on remedies to ensure that revised legislation addresses the future needs of long-term care in partnership with community interest based groups. I'm going to make some points that are in our brief. The points I'm going to be making are in a slightly different order than in our brief.

(1) Admission: facility and the applicant: We are proud of the care provided at Villa Colombo. Our seniors also have a cultural and spiritual environment which permits them to live in dignity, fully able to communicate and participate in decisions affecting their lives. I emphasize that neither the taxpayers nor the government pays for the sensitive cultural and spiritual environment of Villa Colombo; the community provides these additional quality-of-living values. Our community will continue to do so as long as there is an incentive. Bill 101 provides for no participation on who is admitted to a facility and no right of an applicant to choose the facility he prefers.

Our recommendation number 1: We recommend that the legislation ensure that an applicant may apply for admission to the facility of his or her choice and that a facility may give preference to those applicants who would most benefit from available services, with access through the community where feasible.

A central registry is a valuable tool, but admission, particularly where there are cultural or spiritual considerations, must be dealt with at a local functional level. Admission choice should be mutual.

(2) Service agreements with the crown: In the proposed legislation, through service agreements, the province assumes total control and authority over operations, regardless of past or present resident and community participation in funding.

Our recommendation number 2: We recommend that the legislation ensure that the service contract is mutually agreed upon and acknowledges particular community or cultural sensitivity as part of the service contract.

(3) Equality and equal access for seniors: The proposed Bill 101 holds no commitment to equality or equal access for seniors whose mother tongue is not English or French or who have special cultural or spiritual needs.

Our recommendation number 3: We recommend that the legislation ensure protection for those whose mother tongue is neither English nor French, where there are facilities providing specific cultural and spiritual sensitivity.

(4) Community group governance: I earlier spoke of the role of volunteers in building and operating Villa Colombo. This is true of many non-profit homes whether culturally based or not. There is no profit motive in a charitable institution. Board members overseeing operation have no vested interest. Their concern is the best possible care and life of the residents. Cultural aspects do not cost government or taxpayers.

The proposed Bill 101 provides no mention or motivation for any community or non-profit group to build and/or financially support a facility when it has no governance control and therefore does not provide incentive for volunteer sector participation. The partnership between government and community groups is beneficial to the citizens of Ontario.

Recommendation 4: We recommend that the legislation ensure non-profit community groups, where numbers and organization warrant, may receive special consideration to ensure delivery of culturally sensitive services.

(5) Consumer or facility appeal: The proposed Bill 101 has no appeal for the consumer other than eligibility and no appeal on any matter for any facility. If legislation regarding admission is not a decision made by the applicant and the facility, there must be appropriate appeal mechanisms.

Recommendation 5: We recommend that the legislation ensure an equitable appeal procedure on admission, placement, service agreements and care assessments. The appeal body should include providers and stakeholders.

(6) Care standards: The proposed Bill 101 would enforce care standards based on annual assessments by the government which do not permit any funding flexibility for changing needs.

Recommendation 6: We recommend that the legislation ensure rights to negotiate care assessment levels where there is potential for a negative impact on care for residents.

I have two further comments before I finish speaking. We believe that community groups will continue to try to raise funds for provision of care beyond minimum standards set out in legislation. We urge you not to penalize these groups. We recommend that groups which raise and utilize funds from the community to improve quality of living not have such funds deducted from the basic funding formula.

We also feel very strongly that a clause containing the same meaning as subsection 2(1) of the Nursing Homes Act be included in Bill 101 and applicable to all long-term care legislation. That subsection states:

"The fundamental principle to be applied in the interpretation of this act and the regulations is that a nursing home is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."

That last recommendation precedes the residents' bill of rights in the Nursing Homes Act. These sections were added to the act at the standing committee hearings upon the insistence of the Honourable David Cooke, the Minister of Education, who was then Health critic.

We recently met with the Honourable Tony Silipo, Minister of Community and Social Services, regarding our concerns about Bill 101. During that meeting, he led us to believe that there would be some changes to the proposed legislation prior to presentation to the cabinet committee on social development and final reading in the Legislature. We hope today to receive confirmation of these changes from this committee.

I thank you for your attention. We would like to hear the changes to the bill which we will be recommending and welcome any questions that you may have. The Chair: Thank you very much for your presentation. I guess I should indicate that the committee is still at a hearing stage. We've not begun clause-by-clause discussion, so I'm not sure whether perhaps at the end you're really directing your questions to the government. But we will be doing clause-by-clause in a couple of weeks' time. With that, we'll go to questions.

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Mr Jim Wilson: President John, I just want to congratulate you and the volunteer directors on your board of directors for really what's an excellent presentation and the accompanying submission, which contains your detailed thoughts on how to improve this legislation.

In spite of what you've just said, Mr Chairman, regarding the fact that we're still in committee hearings. I think the government has known for quite some time the concern of Villa Colombo and many other charitable homes for the aged that are very concerned that this legislation isn't culturally sensitive, nor is it sensitive to the spiritual needs of their residents. Given that Dave Cooke, while in opposition, really was a firm believer and subsequently was able to have incorporated into the Nursing Homes Act subsection 2(1), as outlined in the back of John's brief. I'd like to ask the parliamentary assistant whether there's a commitment from this government to include in this legislation what is already included in the Nursing Homes Act, which is this interpretation clause which ensures that the act will be interpreted in such a way that is sensitive to the physical, psychological, social, cultural and spiritual needs of the residents.

Mr Wessenger: What I would indicate, however, is that certainly the suggestion will be given serious consideration with respect to applying the same principle to the other acts. I think that's fair to say.

Mr Jim Wilson: The frustrating part of the way this government deals with committee hearings is you think these are your public hearings on this bill. You know, prior to having presented this in the Legislature or shortly after you presented this in the Legislature, that many, many groups have asked for exactly this. I don't know for the world of me why you can't just make a commitment now. This isn't something new that Villa Colombo's brought to your attention today; it's not something new at all. It's something that exists in the current act. So I can't take your words of assurance to the bank and this group can't take as satisfaction.

Mr Wessenger: I think, as parliamentary assistant, I can't make commitments on behalf of the minister. I can only indicate that certainly there is a desire, first of all, to ensure that consumers' choice is made clearer in the legislation. That's been stated on many occasions, the fact that consumers' choice is paramount in this situation and that the whole placement coordination system is to work on the basis of consumer choice.

Secondly, I certainly think it's a very good suggestion that has been made by the Villa Colombo, as it's been made, I think, by perhaps other groups with respect to looking at it, incorporating either the same language or similar language in all the acts.

Mr Jim Wilson: Mr Jackson has a supplementary on

Mr Jackson: The concerns raised by our caucus are not simply limited to the right of access to a facility; it is that the legislation, as it's written, can materially change the face and the atmosphere of a facility. Four years ago I was in a facility and it was a home for the aged, built for the faith community. I brought a religious icon as my token for their common area, "chapel" area. When I gave it to them, I said, "Where's the crucifix?" They said: "We're not allowed to put it up because as a condition of getting the moneys to build the facility, we could not have something that discriminated by faith."

Now, these fears are legitimate. This concern does not simply extend to the notion of admissions; it extends to the notion of religious icons and other symbols that exist in an existing home. As this government is fond of removing certain symbols which it considers passé or exclusive in nature, we are here to say and serve notice that under no circumstances do we wish to see those symbols removed from those kinds of facilities. Before we get any reaction, I would ask that the matter be looked into because it's already surfaced in the preconditions for grants in terms of construction for some facilities in this province. These are legitimate fears that we're putting on the record and we want something more than simply the words, "It's simply an issue of admission."

The Chair: Did you have a comment you wished to make on that? No?

Mr Jim Wilson: Mr Chairman, perhaps I could just ask the witnesses a quick question to do with governance. My impression from your presentation is that if changes aren't made, if your volunteer directors and your board of governors are not respected in this legislation, you are going to have difficulty attracting volunteers to serve on your board of directors.

Mr Capo: From my own personal involvement, I would certainly say so. Our particular board has 22 members. As I've indicated to you, there are also members here from the ladies' auxiliary and a great number of volunteers who work and raise money annually for Villa Colombo. The reason we do this, a great reason, is because we are doing it for the good of, in this case, our own community, the Italian community.

I certainly think and would submit to you that if the control, as it seems to me, is going to be taken away, from what I read in the legislation—most of it is not well defined, because it talks about regulations—it certainly would no longer be an incentive to serve on a board, because we would have no real say in perhaps policy and admissions and other matters relating to the home.

Mr Jim Wilson: And no incentive to raise money. You don't raise money just to meet basic care requirements; you raise money so that your residents can be comfortable in their own culture.

The Chair: I'm sorry; we have to move on.

Mr Drummond White (Durham Centre): I just have a couple of questions. First off, I'm not sure what the result of that particular question that was just posed is, but

I'd like to hear it. I know that in my neck of the woods, Durham—I represent Oshawa and Whitby—we're working hard to secure services for the Italian community there. The Italian community is a very vital part of our area. People like Peter Composio and Carmen Germano are a really vital part of our mix. Do people from Barrie, from Peterborough, from Oshawa have access to Villa Colombo?

Mr Capo: I would say yes, if I just might confer with Mr Glover.

Mr George Glover: We're very happy and proud to be able to share all of our knowledge. We are beneficiaries of knowledge from other homes, of course—the Jewish community and others—and we receive inquiries and visitors and guests from not only around the province but certainly from around the country and indeed from other countries in the world as well. Villa Colombo is well known and we are only too willing to offer any of the knowledge we've gained over the years to any other facility.

Mr White: I'm wondering specifically, though, if Italian-speaking people in our community needed residential services, needed some extra services that weren't available locally, can they secure those?

Mr Capo: We do have residents from outside of Metropolitan Toronto. The residents of Villa Colombo are not just from Metropolitan Toronto. We have them from as far away as northern Ontario; I think we've had one from northern Ontario. Everyone is welcome. It has been my experience as president of this board for the past year that whenever I meet and discuss seniors' issues with members in our community, and this is very important, if someone is Italian and applies to Villa Colombo only because he speaks the language, I think it's important to note that Villa Colombo offers other services as well in the community. We're trying to expand those services, one of which is a service of information, a referral service in Italian at Villa Colombo. Anyone can call Villa Colombo to get information and to hopefully receive some assistance.

Mr White: Can we have a clarification on that matter that was raised earlier about cultural or religious icons?

The Chair: Yes, we will. I'm going to go to Ms Sullivan and then there were a couple of clarifications the parliamentary assistant was going to make.

Mrs Sullivan: I just wanted to assure you that if the clarification from the parliamentary assistant isn't that cultural sensitivities and sensitivities with respect to physical requirement and psychological requirements and religious sensitivities aren't promised by the government, we will certainly, from this side of the House, be having amendments put forward for consideration. Those issues are very much on the table; they have been throughout the hearings.

I'm very interested in two questions you raised in your brief, one with respect to the role of your board in association with the service agreements, because the service agreements will outline the responsibilities of your home and the services which are provided in terms of what the government's expectations are. I wonder, have you had an opportunity to see the draft manual?

1640

Mr Capo: I have not, personally.

Mrs Sullivan: I wonder if it might be useful, then, if the ministry could make a draft manual available to you, because I would be very interested in knowing, by example, who will sign your service agreement with the government.

Will it be considered by the board after negotiation or will it be signed by the administrator who is then brought on by the board? And then who will have the legal responsibility, in a home such as yours, for ensuring that the service agreement is maintained? Who will be responsible, in terms of your operation or other charitable home operations, for ensuring that the culturally sensitive programs that you have agreed to provide are provided? I'd be interested in knowing that.

The second thing I'd be very interested in knowing—I was pleased to see, once again, that there have been two or three other groups that have spoken about the appeal process—is that you have mentioned the appeal process and indicated that you believe the facility should be part of the appeal as well as the resident appealing eligibility or ineligibility to be there.

The other aspect that I'm asking you to consider and address for us today is whether the appeal process, as it's written in the bill, is an appropriate one when the appeal process is to the Health Services Appeal Board, which is quite removed from the local home, or whether a less formal appeal process with respect to eligibility for admission, by example, or to appeal the placement coordinator's determination of eligibility might be more appropriate.

Mr Capo: As I read the bill right now, the only appeal which relates to the two pieces of legislation that govern our home is only an appeal where a resident has not been admitted by the placement coordinator. There's no other appeal whatsoever.

Mrs Sullivan: That's right; exactly.

Mr Capo: We don't think that's appropriate. We think there should be an appeal not only at that stage but an appeal at the stage when someone is asked or told to go to a certain home. This should be able to be appealed not only by the resident but also by the facility. We're not sure, under the present legislation, in that section, as to whether there's any standing. It seems to me, first of all, there's only a one-person appeal which we think should be made larger, two or three individuals, and those individuals should come from both sides, from the workers in the field and also from government. Going back to the appeal itself, we don't know at this point in time, from the legislation—I would doubt if there's any standing, at the first appeal level, of anyone else other than the resident who has been denied access and the placement coordinator.

We certainly think that is not a proper appeal procedure under this act. There should be an appeal procedure for other aspects of the act, as we've pointed out, with respect to matters relating to funding and other matters as well.

Mrs Sullivan: Good. I'd like to talk to you more on that later, but I think the Chair is going to chop me off right now.

The Chair: Chop. I'd just like to ask the parliamentary assistant to comment on it with a couple of clarifications.

Mr Wessenger: Thank you very much for your presentation. First of all, I'd like to make clear that add-ons will not be deducted. In fact, I think we very much encourage you to add on programs that do enhance the residence.

Secondly, just with respect to Ms Sullivan's comment about charitable homes for the aged, of course, as you well know, you have your own bylaws, and your bylaws determine who signs the service agreement. Under a normal corporate structure, I would assume the service agreement would go to the board for approval.

Lastly, some of the indications raised that the government did not fund chapels or was somewhat—I'd like to indicate that the government policy has been to fund chapels in homes for the aged on a 50-50 basis. I don't see any reason for that changing. Also, with respect to the multicultural aspect, I understand there are 13 multicultural homes for the aged presently under approval.

Mrs Sullivan: "Under approval." What does that mean?

Mr Wessenger: I'll ask Mr Quirt to clarify.

Mr Quirt: A total of 660 beds operated by non-profit multicultural corporations are expected to come on stream in the next 18 months to two years.

Mrs Sullivan: How many are on stream now?

Mr Quirt: I believe one of the 13 facilities approved is operational and a number of others are at various stages of construction at this time. We can certainly provide the committee with a report on which groups received how many beds, where they're located and when they'll be opening.

The Chair: Thank you.

I want to thank you for coming before the committee, and I hope you have received some of the direction you were after. As I mentioned before, the committee will be doing its clause-by-clause in a couple of weeks' time, and then of course it's reported back to the Legislature.

Mr Capo: I look forward to the clause-by-clause. We'd like to have a look at that, and we would also request, if possible, to have additional input at that time once we see, hopefully, the amended legislation. Thank you.

The Chair: Thank you very much, and thanks again for coming before the committee today.

Members, we will now have a short recess while our next representatives, from the Bob Rumball Centre for the Deaf, get organized. So if you could just stay close, we'll stand adjourned for a couple of minutes.

The committee recessed at 1646 and resumed at 1656.

BOB RUMBALL CENTRE FOR THE DEAF

The Chair: Good afternoon again, ladies and gentlemen. We're ready to proceed with the presentation from the Bob Rumball Centre for the Deaf. Just before turning the microphone over to—

Mr Jim Wilson: Mr Chairman, I think the people in the back of the room would like the interpreters to stand up because they can't see them. The Chair: There are a number of interpreters doing different functions today, so I think we've got everybody carried

Mr.Jim Wilson: Okay.

The Chair: Just before turning the microphone over to Reverend Rumball, the request was made, and I think it is a good one as some of the people here today are also visually impaired, if we could introduce ourselves so that they could be made known to everyone in the audience today. I will begin and if we can move then to my right. I'm Charles Beer, I'm the Chair of the committee.

Mr Gary Malkowski (York East): I'm Gary Malkowski.

Mr O'Connor: Larry O'Connor. I'm the member for Durham-York.

Mr Owens: Steve Owens, MPP, Scarborough Centre.

The Chair: Sorry. If you could just go a little slowly because they need to get the whole name out.

Mr Owens: Steve Owens, MPP, Scarborough Centre.

Mr White: Drummond White, member of provincial Parliament in Durham Centre. That's Oshawa and Whitby.

Mr Jackson: Cameron Jackson, the member of Parliament for Burlington South.

Mr Jim Wilson: Jim Wilson, member of provincial Parliament for the riding of Simcoe West and Ontario PC Health critic.

Mrs Sullivan: Barbara Sullivan, member of provincial Parliament for Halton Centre and Liberal Health critic.

Mrs O'Neill: Yvonne O'Neill, member of provincial Parliament, Ottawa-Rideau.

Mrs Fawcett: Joan Fawcett, member of provincial Parliament for Northumberland.

The Chair: The final thing I'm going to do before—oh, sorry. The final thing I'm going to do is to cut off the parliamentary assistant. No.

Mr Wessenger: Paul Wessenger, MPP for Simcoe Centre and parliamentary assistant to the Minister of Health.

The Chair: Thank you. Those are the members of the committee and the other persons you may see at the front with us are members of the staff of the ministry or of the Legislative Assembly.

It's not often as the Chair that a member of one's family is appearing before the committee. So I just want to recognize my wife's aunt, Aunt Emma, who is from Brampton and who's here today with the group. Aunt Emma, hi.

Now with that, Reverend Rumball, if I could turn the microphone over to you, perhaps you'd be good enough to introduce the members of your delegation and then please go forward with your presentation.

Rev Bob Rumball: We're privileged to be here before the standing committee and you honourable members. You're going to hear from the deaf and deaf-blind themselves so that you'll get it from the consumers who are very much concerned about what they see happening, because it's a continuation of what has been happening for the last 50 years.

We have Peter Virtue, the executive director of the Bob Rumball Centre for the Deaf on Bayview Avenue. Next is Dorothy Beam who has been a leader in the deaf community and is also on the continuum of care committee at the Bob Rumball Centre for the Deaf. Next is Robert Lock, a blind-deaf resident, and he has an interpreter with him. They will take over and make their own presentations, then I may wrap that up and then I hope we can deal with questions that you might have.

Mr Peter Virtue: Ladies and gentlemen of the standing committee, I am pleased to be with you this afternoon. At the same time, I want to thank you for giving us special consideration and the extended time period. That really is a pleasure, and we thank you very much.

The Bob Rumball Centre for the Deaf has been serving the specialized needs of the deaf and deaf-blind for 14 years. The Bob Rumball Centre for the Deaf is the only facility in Ontario that provides services to deaf and deafblind individuals and seniors.

As a service provider, BRCD has many concerns about Bill 101. Many of our colleagues in the long-term care field have had the opportunity to address the committee regarding specific issues related to placement choice, funding, accountability and the impact on quality of care. We share these same concerns. However, today we would like to focus on Bill 101 and the impact it will have on the deaf and deaf-blind seniors specifically.

The government discussion paper Redirection of Long-Term Care and Support Services in Ontario outlined specialized services for individuals with sensory losses. Bill 101 does not address these needs. How does the government propose to ensure that these specialized services will be met?

Furthermore, how will deaf and deaf-blind seniors access the services of the placement coordinator? Will they have the expertise required to assess their very unique needs? This would seem to be almost impossible and an extremely expensive task, given the number of PCs across Ontario. We have proposed in our submission to the committee that a specialized PC who is sensitive to and experienced with the unique needs of deaf and deaf-blind seniors be appointed with provincial responsibility.

We recognize that the eligibility criteria which will be part of the regulations of Bill 101 are in draft form. We have seen the criteria and are very concerned about the impact this will have on deaf and deaf-blind seniors. In its present state, admission to a long-term care facility is determined only on medical and safety aspects. What of the individual's psychosocial needs?

When deaf and deaf-blind seniors are denied access to local services, isolation occurs. To understand and be understood is a primary need and right. Deaf and deaf-blind seniors living in the community are unable to access local services. They cannot communicate with those around them. Communication with hearing family members is usually limited. In order to meet their psychosocial needs, deaf and deaf-blind people must have the ability to com-

municate. When there is no communication, isolation occurs, and isolation can kill.

For this reason, many deaf and deaf-blind seniors will choose to move to the Bob Rumball Centre for the Deaf, not for health reasons but for the social interaction and communication. Deaf and deaf-blind seniors must not be deprived of this choice. We ask that you consider expanding the eligibility criteria. The government must recognize that deaf and deaf-blind people are only serviced when they can access communication and information. Thank you, Mr Chair.

Mrs Dorothy Beam: Ladies and gentleman of the standing committee, allow me to introduce myself. My name is Dorothy Beam. I am actively involved with the continuum-of-care committee at the Bob Rumball Centre for the Deaf. My deaf friends and I are here today to share with you our concerns regarding Bill 101.

There are some things I would like the standing committee to know. One of these things is that, barring any physical or mental handicaps, deaf people do not consider themselves disabled; rather, we consider ourselves a distinct linguistic and cultural community bound together by the need for visible communication everywhere. Sign language and the written word are our communication mode.

Deaf people need to be together because of the way we interact with each other, using sign language to communicate. We began our education and psychological-social growth within our culture when we attended the then-only school for the deaf in Belleville, Ontario. When the graduates left for their scattered homes throughout this province, they kept in touch through reunion conventions and church rallies. Organizations for the deaf published newsletters and there were many members known as the "old boys and girls network."

Over the past 13 or 14 years the Bob Rumball Centre for the Deaf has developed and provided services that meet the special communication and cultural needs of deaf seniors. There is an elderly persons centre, which provides social events, community support programs, group trips, meetings and also interpreters when needed. Communication is very visible there, and the doors are open to visitors from the outside community who wish to come in to visit. Newsletters are published bimonthly, and this way the Ontario deaf are kept informed.

In spite of advanced technology we now have, there are still instances of isolation and loneliness for elderly deaf citizens outside of the centre. Regardless of loving family or caring professional care givers, if sign language is not used, nor any social interaction with peer groups, isolation occurs, leading to unhappiness and some mental deterioration, even some deaths.

The Bob Rumball Centre for the Deaf is a home and a haven to those fortunate deaf seniors who wish to live and die together as they began their school life together. Will Bill 101, as it stands, allow them this? I do not think so, for when I read and studied it, I could see the need for amendments. I hope you will agree. Thank you for your attention, ladies and gentlemen.

1710

Mr Robert Lock: My life at the Bob Rumball Centre for the Deaf: Good afternoon, ladies and gentlemen. Thank you to the standing committee for inviting me here to speak today. My name is Robert Lock and I am a deafblind resident of the Bob Rumball Centre for the Deaf.

Although I am a diabetic and require some medical services, this is not the only reason I have chosen to live at the Bob Rumball Centre for the Deaf. The staff are both hearing and deaf and are able to communicate with the deaf and deaf-blind senior citizens by different means.

I participate in Monday activities, in bingo every Tuesday, and I go to the news and drop-in for the deaf and blind on Thursdays. I also can socialize in the dining room and in the lounge with the deaf and deaf-blind when I want. If I lived in a different place with only hearing people or someplace other than the Bob Rumball Centre for the Deaf, I would have few friends and the staff and volunteers would not be able to communicate with me. I would be very lonely. Through intervention I can access my needs. If my life was without intervention, I would not get along on my own. The Bob Rumball Centre for the Deaf is a very important place for us, for me and others. Thank you.

Rev Mr Rumball: Robert has just been seeing with his fingers, talking with his hands. He grew up in Hamilton, Ontario, and at the early stages of his life was only deaf. He acquired the blindness later on, so he has known that aspect of life as well.

Until very recently there was no place for him to go; we had jails and mental hospitals. That's simply because, in the wisdom of the legislation over the years, deaf were not supposed to be allowed to teach; sign language was forbidden in the schools; they couldn't be adoptive parents. In fact, BRCD exists today because it was made an exception to the rule.

You see these badges. They say "No Isolation." Now, they call it isolation. You may call it mainstreaming, normalization, integration: fancy catchphrases that have been the greatest curse to people in special needs who need special resources and special residential care.

I found it very difficult to understand why there was such a serious barrier to overcome. Even ministers said: "We don't have to explain. We don't have to tell you. Those are the rules and that's the way we're going to run our province."

Today we have a few deaf-blind residences that are very recent, simply because someone came along and said that the expense of doing the wrong thing and the waste of human life is disastrous.

We don't have a nursing home for deaf people today and as a result, BRCD is providing some nursing care, really outside our mandate, simply because they think all you have to do is integrate them and provide the service in a facility where there is no communication, no understanding and no opportunity to really be understood.

One of our great concerns about Bill 101 is when we read about the fact that some provincial coordinator is going to make decisions about people he or she knows

nothing about, culturally, linguistically, psychosocially, educationally, in any area of their life. Yet these people are going to be empowered to make the kinds of decisions that put a place, which is meeting a special need for special people, not in the driver's seat where it belongs but simply as a dumping ground, because the provincial coordinator could end up referring and sending people there who really, number one, didn't want to be there, don't fit into the environment in any fashion, cannot either serve the community or be served by the community intelligently.

720

If we're just providing warehouses, we don't need the kinds of services that are going to meet their needs. Warehousing may be all right for countries where the state is supreme and makes all the decisions, right or wrong, and where people have no rights. I think Ontario is better than that. It should be better than that, should be open and willing to be informed, willing to seek consultation from the consumer, willing to take a look and find out what the real needs are and not some fancy philosophy that has never worked, even though that's the philosophy and that's the policy that I have had to face for 38 years with the deaf.

It never made sense when I started and hasn't made sense anywhere along the way. One of the strange things is that the rest of the world and 60 other countries have come to see what we're doing and think it's marvellous, think it's great, but they always have the question because they say, "Philosophically, what you're doing here is not what your government proposes."

It is the best thing that has happened anywhere in the world, because the deaf were consulted. They were not only the consultation group; they were the group. It is owned by deaf people primarily. With the help of a lot of hearing friends, it became possible—and with the cooperation of the government at that time, which made all the exceptions to make it possible not only for us to have long-term care for seniors, but under the same roof to also serve adults and youth and children and vocational rehabilitation and preschool and day care. We actually think that family orientation is the best answer to any problem that exists because it's the total picture meeting the total need.

I know that flies in the face of a lot of philosophy. The fact that the results are excellent, better than anything else that exists, should I think be an indication that somewhere along the line somebody just might ask, might consider, because in all the presentations we have made before select committees and royal commissions, I have never seen any of the intelligent proposals by the deaf community incorporated into the legislation, and that involves Health, Community and Social Services, Education and Correctional Services, and they have been presented on a regular basis down through the years.

We're hoping that Bill 101 through this committee and the legislation that eventually comes about is not just a change but a change for the better. Changing for the sake of change is not very bright. Changing because it's an improvement and is going to provide a greater opportunity for service and provide more freedom of choice involving

the consumer group in what is being provided would, I think, be good legislation.

You're welcome to ask any questions of any of the members here because your questions will be interpreted for them and they can respond and you can direct your questions to them. They live it. You and I, except for Gary, don't have to live it. We can opt out any time we want.

The Chair: Thank you very much for your presentation and also for the other documents which you have left with the committee. We'll move right to questions and begin with Mr O'Connor.

Mr O'Connor: I think that you're perhaps a little bit shy in saying—like Dorothy Beam here. She's a recipient of the Order of Ontario, so we're really honoured that she has come here and brought all her friends with her.

I have talked to Gary Malkowski about some of the things that do take place at the Bob Rumball Centre. He gave me a copy of the elderly persons' centre program and news and I find it very informative. I'm sure that the members of your community find this sort of keeping in touch with everybody is really important.

You've brought to the committee a copy of the annual report, and for the committee members, they may want to just take a look on about the third page in. I notice there's a picture of young Christopher Malkowski, who is the son of Gary Malkowski, so I'll embarrass him perhaps a little bit.

Gary—as well as Paul Wessenger, the parliamentary assistant to the Minister of Health—has talked to me on a number of occasions and has shared with me the consultations. Your community has certainly gone out of its way in making sure that presentations were made not only to the committee but to the government. Your concerns have been heard.

Gary shared with me the presentation that was made, and I believe this goes back to March 1992. Not only did you make a presentation at that time; following that you presented a follow-up just to make sure that all the necessary points of view you wanted to get across, talking about access and accommodation, did come forward. I guess for us committee members this is probably one of the unusual opportunities where Gary didn't need the interpreter, because he had people from his community here, but we needed the interpreter.

I think that, taking a look at your brief, you made some very good recommendations. On page 4, you talked about a specialized placement coordination that would take a look at the provincial responsibility. I know that's something Gary has talked about and I think that's a very reasoned approach, an approach we're definitely going to look at. It's something we thank you for coming to the committee about because it's a view you brought forward to us.

You've stated in your presentation, the brief, that in order to meet the psychosocial needs for deaf and blind people they need to communicate. I think you've stated that quite well and eloquently today. What I'd like to do at this point is get an interpretation from the bureaucrats within our ministry to give some assurance that the needs of people presently residing in the Bob Rumball Centre are

going to be recognized and that the needs of future people who would like to go into the Bob Rumball Centre, whether they're deaf or hard of hearing, get recognized. If I could get a clarification from Geoff Quirt, I'd appreciate that

Mr Wessenger: Perhaps I will attempt to give the clarification, and if any additions are required by staff, they can clarify. We recognize and appreciate the suggestion with respect to the specialized placement coordinator and we recognize the fact that it's a requirement to have such a person designated. I have received assurances from ministry staff that the selection of that will be done in consultation. It will not be done except on a consultation basis. The second aspect of course is that it's already been recognized that psychosocial needs should be taken into consideration as well as medical and safety aspects.

Again, I'm very pleased with the recommendations that have been made. They're very realistic recommendations and ones that obviously we have to ensure are met.

The Chair: I'll next recognize Christopher Malkowski's father.

Mr Malkowski: I want to congratulate all the presenters who have come forward from the community today, both deaf and deaf-blind people who have come forward. It was quite a beneficial experience, I think, for everybody. I think it had a real impact. I think it's really important for those of us in public office to hear from people in the community for constructive change.

At the same time, I would like to say that I agree with Mr Rumball about his experiences coming to speak over the past 38 years or so. I guess it's true in fact to say that throughout history governments haven't always listened. All three political parties have been the government at one point or another and what's true is that none has ever actually implemented recommendations that came from the deaf community.

I'd like to see this as a non-partisan issue and I'd like to work for the betterment of our community and work with the opposition members and also people within our party, the government, to make sure we can better the lives of deaf and deaf-blind people and senior citizens to recognize your wishes and your needs.

But I do have a question for Dorothy Beam. I'm reading in your recommendations where you talk a little bit about feeling it's worth it to have a placement coordinator who provides services to recognize consultation with the deaf community first, to make sure that consultation happens with a placement coordinator, to make sure that person has the understanding of the psychosocial needs and the cultural needs? What kinds of things would you recommend that the placement coordinator have to do the job?

Mrs Beam: Yes, I feel it's very important. I'd like to see someone, maybe even a deaf person, a graduate from a university—I don't know—or a hearing person who's skilled in sign language who understands the deaf, that the PCS would allow information—say you're not deaf, so you can't live in that society—"You can't move to that one; okay, we'll take care of you in your home and take care of you here," but it doesn't understand the psychosocial needs.

So I think it's very, very important that the government pay for at least one person who is skilled in deaf culture, sign language and have the person travel all throughout the province and the deaf person could ask that person for help.

1730

Mr Malkowski: Just for the record, if I may have an opportunity to speak with our Minister of Health, Ruth Grier, and also the parliamentary assistant, Larry O'Connor, to make sure that your needs are met and considerations to make sure that there is no isolation happening.

Mrs Sullivan: I'm not quite certain who to address this question to, whether it's a series of questions for the ministry or for our witnesses today, but I'd like to know more about the needs of the deaf-blind community. As you know, Bill 101 calls for placement coordinators for each long-term care facility. The Bob Rumball Centre, as a charitable home for the aged, would therefore have a placement coordinator assigned to that home by the minister. We don't know some of the other responsibilities of that placement coordinator because that's left to the regulation, but there would be a placement coordinator for your facility.

You've indicated that there are other deaf-blind residences in Ontario. I am unsure if the one placement coordinator for the deaf-blind community, as you have suggested, is in fact appropriate, or are the placement coordinators for all of the facilities the more appropriate way to go? Rather than one Ontario coordinator, which you have asked for, is it not perhaps more appropriate that where there are long-term care residences that serve the deaf-blind community, the placement coordinator be associated with each one, which is in fact what the legislation calls for? I don't know who is going to answer that one.

Rev Mr Rumball: Our experience is that every time the government has somebody, we liaise. The minute they become informed and knowledgeable, they are transferred, and you have a re-education process and you start it again. BRCD serves the deaf regardless, not limited to geography: Hamilton, Peter Virtue; Chatham, Dorothy Beam. Almost everywhere in the province it requires somebody who is not serving an area geographically, maybe serving a centre but dealing with people, because we have them from other provinces as well.

Whether you can find that kind of person—Dorothy suggested that placement coordinators might be deaf or blind and deaf. That would eliminate some of the mystery, because they're part of the problem and therefore they are most likely to have some idea of what the answer might be. I'm not sure whether it's been made clear that each centre has its own placement coordinator, because if you're doing that, why wouldn't he or she be a member of your own staff, and you're doing exactly what you're doing now better than anybody else has ever done it?

Mrs Sullivan: Those are some of the questions we've been asking too. That's exactly right. Are there other deafblind residences?

The Chair: I believe Mr Virtue had a comment to make as well.

Mr Virtue: BRCD is more than willing to work together with the government in choosing a placement coordinator. From what I've read from Bill 101, it seems there'd be one person who's a placement coordinator and maybe two or three other people who are representatives of the deaf and deaf-blind. BRCD is more than willing to work with other organizations in services for the deaf and deaf-blind to make sure that their needs are met.

So several people could work together. That way we make sure that the needs of the deaf, the deaf-blind, the hard-of-hearing and the deafened are met.

Mrs Sullivan: Can I have a supplementary? Then I think the parliamentary assistant wants to respond too.

Rev Mr Rumball: Let me answer one question we haven't had answered yet. In North York on Willowdale Avenue there is a very special residence of 16 apartments for independent blind-deaf individuals.

Mrs Sullivan: Seniors?

Rev Mr Rumball: It's fairly recent, fairly new, opened a year ago. Some of the workers from Hand Highway—it's Hand Highway to me; it's CNIB—are knowledgeable about that. They were involved in the process. It was a product of the Don Valley Rotary club and the provincial government. Then Community and Social Services bought homes for blind-deaf children in Newmarket and in Richmond Hill, and the Lions built a place in Brantford, Ontario, close to the school for the blind where blind-deaf youngsters are educated.

Mrs Sullivan: I suppose my thinking was related to the homes for the aged, charitable homes that the bill affects, rather than for the younger children. Is the Bob Rumball centre offering to become the placement coordination centre for the province for deaf-blind?

Rev Mr Rumball: I think they could probably do it better than anybody else. I wouldn't apologize on that.

Mrs Sullivan: I thought you might want to get that on the table.

The Chair: Parliamentary assistant, did you have anything further to add to that?

Mr Wessenger: No.

The Chair: Mr Wilson and Mr Jackson.

Mr Jim Wilson: Thank you very much for your presentation. It's been most enlightening. As I've read everything you've presented and heard your oral presentation, there are really two concerns: the need for specialized PCS, and you very much want to see the eligibility criteria expanded to include psychosocial needs. I want to tell you that on both those points my party is willing to put forward amendments if the government doesn't do so.

The parliamentary assistant has today said that yes, the government hears you with regard to the need to be sensitive to psychosocial needs, yet this committee has never been presented with any amendments the government may have in that regard. My view is that if the government made up its mind on this several weeks ago, then why does group after group after group have to keep coming and telling us the same thing?

To be quite frank, I won't believe the government until I see its amendments. That'll be in another week and a half, I gather, when we go into clause-by-clause consideration of the bills.

Outside of these two main concerns of yours, have you got other concerns? For instance, I think of governance. We've heard a lot of charitable homes, homes for the aged in particular, very much worried about whether this bill will undermine their ability to control their own destinies and to operate their own facilities. Did you get into any discussions like that?

Rev Mr Rumball: I have some personal concern, but I think that was expressed by Mr Jackson prior, with the icon business. I find it disturbing, as a minister of the Gospel, that the use of the Bible in the centre is a serious problem, but if I wore a turban and a kirpan or anything else it's fairly acceptable. I have a serious problem with the Ontario Mission of the Deaf not being allowed to be the Ontario Mission. They're the owners of the Bob Rumball Centre for the Deaf. It is a community of faith that goes out and serves anybody under any terms, with no hitches at all. But when anybody steps in and says you're not allowed to do and be what you are and that you have to operate under false pretences—personally, I don't do that, not today, not tomorrow.

And it's not just touching this kind of thing, but touching many areas: our schools for the deaf that are residential. They want you but they're not allowed to use you, because all of a sudden you are also a religious symbol and that's unacceptable. I find that unacceptable, because if the school wants me, what they see is what they get. That's also true at the Bob Rumball Centre for the Deaf: What you see is what you get.

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I think it is a concern, so we have that concern. The fact of the appeal process raises some concern. With all of these things, in the past, if we couldn't deal with them rationally and intelligently, then we dealt with them publicly and in the press. But that's a terrible way, when you can't be intelligent and solve your problems.

Mr Jim Wilson: I appreciate your frankness. I'll tell you, with the views you've just expressed, you'd live quite comfortably in my riding of Simcoe county. The vast majority of my constituents would certainly agree with your views that you've just expressed.

Rev Mr Rumball: I have some concern about inspections too, because our experience is that the wrong inspector, with his little book, can come and make it hell for you. We built a centre here. We went to tender with the same kind of devices they have in the provincial schools for the deaf in terms of fire alarms and everything else, except that they didn't pass muster:

The government wouldn't approve them. Then we had to go and pay for the Underwriters' Laboratories of Canada and the Canadian Standards Association and everything to invent and develop a device that the government itself never had to measure up to, even though it was the enforcer of the legislation.

I think that is a double standard that is unfair. Rather than try to create obstacles, they should find answers. Fortunately, we did persevere, we found answers, and the thing's improved. Even the government schools now have qualified detectors and devices and things, but it wasn't because they had to. It's simply because when we brought them on the market, they were cheaper and more intelligent than what they were doing.

Mr Jim Wilson: I hope the government paid you back for your efforts.

Rev Mr Rumball: No, not a penny, but that's all right. We're taxpayers, and if we do it, we do it cheaper than the government would have done it anyway.

Mr Jackson: Rev Rumball, you mentioned philosophy, and I believe you were talking about the concepts of deinstitutionalization and congregation, meeting the needs of a special group of people. There's this tension, there's this contradiction almost. Have you gotten a sense from this government and this legislation that your philosophy is being listened to?

Before you respond, I'll place the other part of my question. I believe placement coordination services and improvement and sensitivity within them for the deaf and deaf-blind community are helpful and laudable, but they have to have a place to go, they have to have a placement. That's really what I consider to be our largest problem. We don't have access.

You were in the room for the previous presentation, when I raised issues around cultural sensitivity. Dorothy Beam, to her credit, has shared with us a wonderful insight. I want to quote from her brief: "Deaf people do not consider themselves disabled; rather, we consider ourselves a distinct linguistic and cultural community bound together." That is your philosophy.

The parliamentary assistant just announced that there are some 16 or 18 projects being made available for culturally bound groupings of people in this province. Why is it that you're not being considered?

Rev Mr Rumball: Because they don't consider what she said a valid representation of the facts. They think they're doing us a favour, because they think we're disabled and handicapped. Therefore, since they're going to normalize and integrate and mainstream all handicapped people whether they want it or not, they're going to do it with the deaf. And it doesn't work; it never has worked, and it denies them the freedom of choice.

Mr Jackson: I had a deaf uncle, and he taught me the concept of being differently abled. It was quite a revelation as a small boy to understand that there was nothing different; it was just that how we communicated was different.

Rev Mr Rumball: You see, our final board is all deaf. Whether it's the centre, the camp, the children's homes, the final board is deaf. We have confidence that they know what they are, and we think we should allow them to be deaf, even though they live in a country that would like to mainstream them and normalize them and integrate them. These are great ideas. The fact that it's never worked doesn't seem to bother the philosophers.

Mrs Beam: I just want to say something. You talked about the special needs of the deaf as a group, as a community, that in other organizations or other places they just wouldn't fit in. We don't consider ourselves handicapped like people who are in wheelchairs, who have a physical handicap, things you can see. We don't want to be clumped in with that group or integrated into those groups. The deaf can't. We need those communication skills, we need to be able to understand, and you need to understand the psychosocial needs of the deaf.

We want to be equals with other groups. I mean, we play games and do activities such as that, yes, but the deaf are not like other groups. Other groups want to be mainstreamed, want to be in social clubs with other groups. We want to live together. We want to have the right to choose that. We like to have people in the government, such as Gary, who can sign so we know what's going on.

So it's sort of different, handicapped people and us. I'm deaf. I'm one who can't hear. Our world is based on sound. Really, it's based on sound. We're happy together, happy to see, happy to understand. So when you talk about

mainstreaming or putting us all together, that's how I have to respond.

The Chair: Thank you very much for coming before the committee today, particularly for the others who have come from your centre and from other parts of the province. We thank you again for the presentation and for the material you have left with us, and I think we all hope that in our deliberations, whatever we do we will be able to further the interests of everyone who has come here today. Again, thank you very much.

Mrs Beam: Will we be informed if Bill 101 is amended?

The Chair: I think I can say very definitively yes, you will. Probably through a number of different routes you'll be informed, but certainly we'll keep you informed.

Mr Malkowski: Would you mind sending copies of Hansard to these people, just for their own purposes?

The Chair: That would not be a problem at all.

With that, this sitting of the standing committee on social development stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1749.

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^{*}In attendance / présents

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Wednesday 10 March 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Assemblée législative de l'Ontario

Deuxième intersession, 35e législature

Journal des débats (Hansard)

Mercredi 10 mars 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Président : Charles Beer Greffier : Douglas Arnott

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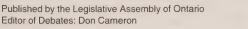




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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 10 March 1993

The committee met at 1008 in committee room 1.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. We begin our hearings on Wednesday, March 10, Bill 101, An Act to amend certain Acts concerning Long Term Care.

ONTARIO PSYCHOLOGICAL ASSOCIATION

The Chair: Our first witnesses this morning are representatives from the Ontario Psychological Association, and I would now invite them to come forward. Have a cup of coffee, some good old Toronto water. Please make yourselves comfortable and, once you're settled, if you would just introduce yourselves for Hansard and to the committee members and then please go ahead with your presentation. Again, welcome to the committee.

Dr Ruth Berman: Good morning. Mr Chairman and members of the committee, I'm Dr Ruth Berman, executive director of the Ontario Psychological Association, and with me is Dr Mary Tierney, head of geriatric psychology at the Sunnybrook Health Sciences Centre. Dr Tierney is a member of our legislation committee and coordinator of our long-term care initiative.

The Ontario Psychological Association is the voluntary organization representing the profession of psychology in Ontario. Our membership of approximately 1,400 includes psychologists, psychometrists and graduate students.

We are pleased to have the opportunity of expressing our views on Bill 101, the proposed amendments concerning long-term care. We have followed the debate on long-term care with great interest and have previously responded to the earlier government proposals outlined in the documents Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services and Redirection of Long-Term Care and Support Services in Ontario. We are pleased to provide members of the committee with copies of these submissions for their information and we have given the clerk copies of our prior submissions for circulation.

The Chair: Thank you. We have both of those documents.

Dr Mary Tierney: In general, as psychologists, we would be in favour of any system which would provide the elderly and the physically disabled with greater control of and autonomy in their lives. We would support as a basic principle the concept that services must be directed at

individual needs, in particular those that enhance and support an individual's independence, dignity and quality of life.

On the whole, we think it is a good idea to combine the acts that govern nursing homes and homes for the aged as well as to amend relevant aspects of the Ministry of Community and Social Services Act, the Health Insurance Act, the Ministry of Health Act and the Municipality of Metropolitan Toronto Act.

However, we have a number of specific comments regarding Bill 101 which we would like to raise with you today. First, we are pleased that the bill amends the Ministry of Community and Social Services Act and allows for grants for persons with disabilities to assist them in obtaining goods and services that they require as a result of their disability. However, there's no mention of the special needs of residents with mental health problems nor how their needs can be met.

Recent studies of Ontario facilities show that 75% of nursing homes and homes for the aged residents have some degree of cognitive impairment. Other studies of the same facilities show that 60% have mental problems resulting from Alzheimer's disease and other dementias, traumatic brain injury, developmental disorders, chronic substance abuse, depression, psychotic disorders and the like.

These individuals often require specialized services and facilities in order that their disorders are accurately diagnosed and appropriately treated. The bill provides no indication of who will screen or validate diagnoses of those with mental problems to determine what level of services the individual requires of a nursing facility.

Psychologists are one of the two professions authorized under the Regulated Health Professions Act to provide diagnoses of mental and neuropsychological disorders. Will there be provision in the regulations to include psychologists in this role? Psychologists are not covered by OHIP. Will this bill ensure that these services are available?

A related issue is that because of their disorders, these individuals may wander, be aggressive or destructive to self or others and exhibit other behavioural disturbances. In some instances, for example, for those at risk of wandering, locked units may be required. The issue of separate units in facilities for those with special needs has to be addressed in the bill. How will this issue be dealt with under the regulations?

A second major concern is in regard to the placement coordinators. As proposed in the bill, placement coordinators will control admissions to nursing homes, charitable homes for the aged and municipal homes. They will be designated by the minister. Who will these placement coordinators be and what will be their level of training? From whom will they seek information? What criteria will they use for decisions regarding admissions? To what extent will cultural, religious and linguistic needs of individuals be taken into account? Who employs these placement

coordinators? It is a clear conflict of interest if it is the facility itself.

If the placement coordinator deems a person eligible, the facility must admit this person unless there are grounds for refusal of admission specified in the regulations. What are these grounds and who will determine whether they are applicable or not?

The Alberta classification tool is the tool that will be used to assess long-term care facilities for level of funding by determining the amount of nursing care required by the individual resident We trust this will not be used as an assessment or screening instrument, as it was not designed to be used in this manner and thus will not provide useful information. Furthermore, the tool does not assess the amount of care required of other members of the multidisciplinary team even in those facilities where such individuals are employed.

A third issue is in regard to the requirement specified in the bill that each resident of a nursing home, a charitable home for the aged or municipal home must be assessed and a plan of care developed to meet the requirements of that resident. Given that the majority of residents will have mental problems, who will develop and supervise the specialized care plans of these needy individuals? Psychologists can play a valuable role in this area.

Psychologists have recognized expertise in the development of behavioural intervention programs to deal with behaviour disturbances frequently associated with dementia and brain damage. Understanding the behavioural implications of neurological damage can assist the care givers in anticipating and interpreting many of the actions of the ones for whom they are caring. Psychologists can train care givers in long-term care facilities to work more effectively with their residents.

The provision of treatment for individuals once they have been admitted to a home under the new act remains of great concern to us. The purchase of services other than nursing appears to fall under "quality of life," a category of funding proposed for the operation of homes. At present, there are no psychologists on the staff of nursing homes or homes for the aged and relatively few within chronic care facilities. Psychologists can provide essential and unique services in the form of psychological assessment and diagnosis, behavioural management of wandering, aggression, depression, incontinence etc.

We understand that this envelope of funding is small and that an entire range of services will be competing for these limited funds, including, for example, special meals to meet the requirements of residents with religious restrictions. We are concerned that if there is no clear statement in this bill of a need for expert psychodiagnostic services and psychological care, these services will not be available to the residents of these facilities.

It should be noted that in the United States specialized diagnostic and treatment services of psychologists for nursing home residents with mental problems in medicarecertified facilities are governed under the pre-admission screening and annual resident review regulations of the Health Care Financing Administration. Similar regulations

are required under the current act to make these essential services available

These are a number of the issues, and there are others as well, related to long-term care which have been fully elaborated in our prior submissions. We are prepared to meet with the committee members for further discussion on these issues at any time and would be pleased to answer your questions at this time.

The Chair: Thank you very much for your submission and, as you indicated, the previous submissions from 1990 and 1992. We'll begin questioning.

Mr Paul Wessenger (Simcoe Centre): Thank you very much for your presentation. I'd just like to indicate to you, for clarification with respect to your comments with respect to the Alberta classification tool, and assure you that it will not be used as an assessment or screening instrument. Further, the plan of care for each resident is to be developed by a multidisciplinary team, of course in consultation with the resident and the resident's family. I just thought I'd give that clarification.

The Chair: Any comment on that?

Dr Tierney: The comment would be that you said the care plan will be developed by the multidisciplinary team. That would be determined by who's employed by the facility. Our concern is that psychologists are not currently employed by any nursing home or home for the aged, so we would not be included in the multidisciplinary team.

Mr Wessenger: Yes, I certainly appreciate the fact that your services are in many cases needed in this multi-disciplinary team.

1020

Mrs Joan M. Fawcett (Northumberland): Thank you for your presentation. Just following up on that, how widely are your services used in the homes or any of the long-term care facilities?

Dr Tierney: Well, probably within this province, the facilities that employ psychologists for geriatric residents are the chronic care hospitals.

Mrs Fawcett: And that's the only area there where you are presently—

Dr Tierney: There are no nursing homes or homes for the aged that actually employ on-staff psychologists. I can refer to examples where I've been employed by a resident or where another psychologist might be employed on a consultation basis, but certainly not on the staff or employed on any kind of regular basis.

Mrs Fawcett: And having done that, you can see the need for an expansion of your services. On the one part of your brief, you said that you're "concerned that if there is no clear statement in the bill of the need for expert psychodiagnostic services and psychological care, these services will not be available to the residents of these facilities." This just all fits together, then. Is there anything further you would like to say on that or how you would like to see it included in the bill? As an amendment, or—

Dr Tierney: Or if it could be included within the regulations, it would specify which members of the team must be included for these kinds of diagnoses.

Mrs Fawcett: Yes. Well, that's a problem. We haven't seen the regulations yet. We know that so much is going to left there, and we're not just sure. But you would think, then, that the place for that would be in the regulations rather than in the bill itself?

Dr Tierney: Or if there could be some recognition, which we also discussed, of the different levels of care required for residents, because that's not mentioned within the bill.

Mrs Fawcett: Right. Thank you very much.

Mr Cameron Jackson (Burlington South): I'd like to build on your current relationship with chronic care hospitals. If you've been apprised of the ongoing dialogue before this committee, you'll be aware that the government has a plan to reclassify chronic care hospitals. We have heard first hand in Ottawa at the Perley, and there are six other hospitals that are currently under negotiations to downsize the level—I'd better be careful—not level of care, because they don't want to admit that, but it amounts to the same when you take highly skilled professional individuals and remove them from that setting. The theory is that we'll have the same level of service. I don't buy that, but that's the way the government, the NDP, are trying to convey it.

Are you involved in those discussions in terms of the staff dislocation, the reclassification of the beds? Because before this committee it has been very specifically and graphically explained to us that there will be fewer medical interventions, which I know include your services. So if there isn't a place for you in the continuum model there, then where is it? And if this is the only place and it's about to be diminished, you're really fighting for some participation in the process of extended care in Ontario. That's really where you're at, because you're losing ground.

Could you respond to some of that in detail in terms of how you've been involved at the Perley, as an example, or in a generic way with the government in its reclassification and downsizing of the chronic care hospitals in Ontario?

Dr Tierney: Well, at present there is not a psychologist at the Perley, so we have not been directly involved there. I could speak to my experiences at Sunnybrook, which are a bit unique because of the role of Veterans Affairs, which provides funding. Therefore, some of the chronic beds are not eligible, but they're certainly under review.

These changes are not just a concern of psychologists within chronic care facilities. They are also a concern of occupational therapists, physiotherapists, social workers, speech pathologists, many of the other professions which are employed primarily in chronic care facilities, because that's where the funding is. With the change in classification based on the Alberta classification tool, which is completed only by nursing— it's not completed by the other members of the team which may have input as to level of care—the individual will be possibly moved from a chronic care facility based on that information. You're right; we're all concerned about that.

Mr Jackson: But don't you as well embrace the notion that it has less to do with the movement of individuals as it does with the extraction of levels of service in those

institutions? We have uncovered during these hearings that the Perley will no longer be a hospital. It cannot be called a hospital and it doesn't have the protections under the hospital act; it will be a long-term care facility and it falls within the ambit of this revised legislation.

So it's less the movement of the individual; their acute care needs are going to be there. Their acuity rate will still be there, but they won't have as many respirators. They won't have the physicians. They won't have what we call the life-sustaining interventions and the psychological interventions that are so important at that level. That's what this committee is coming to realize, as has been explained by Mr Quirt under cross-examination as to what the government's plan really is.

Ms Jenny Carter (Peterborough): First of all, a comment, and then a question. Of course, this is just a barebones act, as you might say, and we are missing the regulations that put the flesh on the bones and this has led to a lot of concerns that I hope in the long run will prove not to have been necessary.

Certainly, your concern about the placement coordination is something that we've heard a lot about but, on the other hand, we have had presentations from, for example, VON groups which are in fact performing that function in their own local areas already and it does seem to work very well. Certainly, the element of choice is very much at the top of the minds of these people and they don't see any reason why this would change as a result of Bill 101. So hopefully that's a problem that will turn out to be non-existent.

It seems evident that psychologists are already not playing as big a part as maybe you should in this whole picture and maybe this is something that we should look at much more closely. I was just wondering if you could fill in for us some of the details as to how earlier intervention by psychologists might lead to people not becoming such serious cases as they otherwise might and how this would save money further on down the line.

Dr Tierney: I'd be happy to do that. I think what we're addressing today is mainly the role of psychologists within the facilities. But, as you've mentioned, psychologists can play a role in the continuum and I think the whole problem is, you have to look at why people are institutionalized in our facilities in the first place. When you see the majority are for mental problems, are we really addressing those needs and have we put any emphasis there in either diagnosing or treating those problems? This is what I think is lacking.

It's just not there, because psychologists can in fact—and often this is what is done. We see this at Sunnybrook all the time. The individual is admitted to a facility and he has not been diagnosed or he has been diagnosed with Alzheimer disease and there's probably about a 50% accuracy rate in this diagnosis. If there's no further workup of this individual, he is treated in that way and there's no chance for any kind of rehabilitation or improvement in function.

What psychologists can do is diagnose these individuals accurately and thoroughly in such a way that not only does

it provide that accurate diagnosis but it's also the kind of diagnosis that can lead to treatment so that if a depression, for instance, has been missed, whereas the person has been labelled with Alzheimer or some dementia, the depression in fact can be treated and can be treated without medication. That individual then can go home.

But because these services are not available, individuals remain in our nursing homes and homes for the aged, misdiagnosed and not treated, and this is what I think is very expensive.

Ms Carter: So existing teams do not include psychologists as much as ideally they should?

Dr Tierney: Well, no, and that's the problem; only within. I think this is what was being alluded to earlier, really. As well, not all chronic care hospitals employ psychologists. Unless the individual's family employs a psychologist on a consultation basis, the individual within the facility doesn't have access to that service.

1030

Mr Stephen Owens (Scarborough Centre): On a point of clarification.

The Chair: Yes.

Mr Owens: Mr Quirt, if, in the writing up of a care plan, it's indicated that the services of a psychologist are to be part of that care plan, and recognizing that psychologists are not an OHIP-covered service, what would be the responsibility of the facility or the resident to pay for the service? In terms of the enforcement of the contract between the resident and the facility, what would happen?

Mr Wessenger: I'll ask staff to reply to that one.

Mr Geoffrey Quirt: I'm Geoff Quirt, acting executive director of the long-term care division. If, in developing the care plan for a resident after the resident was deemed to be appropriate for admission to that facility, it was indicated that the resident could benefit from the services of a psychologist, the facility would have at its disposal the funding available and the quality-of-life funding component of the new funding formula to purchase specialized quality-of-life-related services, including specialized services like the services of a psychologist, an occupational therapist or physiotherapist.

I note, however, as has been pointed out, that the more appropriate point of involvement of a psychologist might be in the assessment stage when a multiservice agency or a placement coordination service was exploring the reasons why someone was considering moving to a facility and exploring community service alternatives and looking at the problems that were presented to the family and the client; that may have been probably an earlier and more important and more productive place to involve that specialist resource.

The Chair: Thank you very much for coming today. I believe we have also had psychologists from several other centres who have come forward, and I think certainly the message has been consistent. We appreciate your being here this morning.

Dr Berman: Thank you very much.

Dr Tierney: Thank you.

EXTENDICARE FAMILY/COMMUNITY ADVISORY BOARDS

The Chair: I now call our next representative from the Family/Community Advisory Boards of Extendicare Guildwood, Extendicare Bayview, Extendicare Scarborough and Extendicare Park Road, if he would be good enough to come forward.

Mr Bill Hayward: I'm here.

The Chair: Welcome to the committee. If you would introduce yourself for Hansard and for the committee members, and then please go ahead. I think we have a copy of your submission in front of us.

Mr Hayward: Good morning, ladies and gentlemen. My name is Bill Hayward. On behalf of the Family/Community Advisory Boards and the several hundred elderly people who live at Extendicare Guildwood, Extendicare Bayview, Extendicare Scarborough and Extendicare Park Road in Oshawa, please accept our thanks for the opportunity to speak to you about Bill 101, An Act to amend certain Acts concerning Long Term Care.

The Chair: Just before you go forward, do members have a copy of this? I guess copies are being made. I'm sorry. There was one here. I guess they're making copies, but please go ahead, and we'll distribute them as soon as we get them.

Mr Hayward: Okay to proceed?

The Chair: Yes.

Mr Hayward: We're going to talk specifically about the impact of the proposed copayment increase that residents of nursing homes throughout Ontario will have to pay to continue living in their homes. At the outset, we wish to go on the record as fully and strongly supporting the 11 recommendations submitted to you by Mr Jim Lumsden, chair of the Council of Family/Community Advisory Boards in Ottawa, on February 24. We believe that your serious consideration and government's adoption of these constructive recommendations are prerequisite to ensuring equity and fairness to everyone: residents, staff, administrators and care givers, all those who will be affected by Bill 101.

In preparing to meet with you today, our members spent a lot of time trying to decide how to most effectively convey to you our concerns, and those of the elderly people we represent, about Bill 101. At first, we considered the facts-and-figures approach—hard numbers, demographics, chronicity rates, province-by-province regulatory and cost comparisons, income levels, forecasts, projections—the type of number-crunching and statistical gathering that all governments generate, or as increasingly seems to be the case, cause the public to generate in order to respond to what we believe is ill-planned, incomplete and unjustified legislation.

On balance, however, we figured that you'd get all the statistics you'd need from other presenters or from your own staff, so we decided to take a more human approach. After all, we can't afford to forget that it is human beings, not statistics, who suffer the consequences of poorly crafted legislation enacted by governments at all levels. With Bill 101, the people who will be affected are among the most vulnerable in our society and least able to suffer

the consequences. In order to discuss Bill 101 on a human level, we believe it is essential for all of us here today to share the same perception, image, if you will, of the people we're talking about.

To do this, I'd like all of you here today to think about an elderly relative or friend, someone who's getting on in years but who still has most of his or her faculties, someone who's still able to maintain a degree of independence in terms of living alone, getting around, using the telephone, shopping—generally speaking, able to take care of themselves.

Hold that picture and think about that individual, relative or friend three to five years down the road, perhaps the victim of a cruel and disabling stroke or struck down by heart disease, arthritis or Alzheimer's. Picture that person having to be fed and bathed, and picture yourself having to sit for hours in a hospital waiting room because of that person's most recent serious fall or burn or attack. Picture that same person with a healthy mind but a deteriorating and unresponsive body. Picture wheelchairs and picture walkers and picture canes, and picture, if you can, anxiety, confusion and, in some cases, severe isolation.

These are the images of many of the people who will be directly and immediately impacted by Bill 101, particularly the unbelievable resident copayment increase of up to 45%, depending on whether the rate goes up by \$10.88 a day or \$11.88 a day, the latter being the third level of increase to be announced since last fall and the latest amount that the government says these people will have to pay. We want you to recall these images of these people as we discuss elements of Bill 101 from a human perspective.

Before most of you is a copy of a letter written by Vera Nicholls. She's the former president of the residents' council and a three-year resident at Extendicare Guildwood. I say "former president" because Vera doesn't live there any more. She had to give up her bed at Guildwood because of a prolonged hospital stay brought on by a series of heart attacks, the last of which hit her after writing this letter. Vera wrote the letter so that it could be read at a meeting we held at Guildwood on December 20 to familiarize residents and their families with Bill 101. She didn't feel she'd be strong enough at the time to speak in person at the meeting.

If I can be permitted to digress for a moment, this was the same meeting to which we had formally invited Premier Rae and the former Minister of Health, Frances Lankin, and although we contacted them more than three weeks prior to the meeting, we didn't receive the courtesy of a reply or an acknowledgement. It was only after I made a series of 11th-hour phone calls within less than 24 hours of the meeting that we were able to confirm that a government representative would attend. Unfortunately, he was unfamiliar with the details of Bill 101, having himself been given very short notice and pressed into service in an instant.

For the record, I'd now like to read Vera's letter. It's dated December 10. As I say, Vera wrote it to be read at our December 20 meeting.

"As president of the residents' council of Guildwood Extendicare nursing home, I wish to express my anger concerning a proposal up before Queen's Park at this time

to increase the residents' share of their accommodation for long-term nursing home care by \$11 per day.

"I find this to be unacceptable entirely. It boggles the mind how anyone can possibly come up with a proposal of this kind. I am strongly against it. These people struggled years ago to keep their homes together under the most trying circumstances and went without so much in order to put a few dollars away for their old age. We have arrived, and we get hit with the fact that we must continue paying for the rest of our lives for care and comfort. We paid our dues long ago. We don't live in the lap of luxury now, but we do have the excellent care to which we are entitled.

"We earned our right to this care long ago. I am wondering what our families feel about this proposal. I hope you will speak up loud and clear and let your thoughts be known.

"Things have come to a pretty pass when our government has to reach into the pockets of the aged and infirm to bolster up a failing health care system. We shouldn't have to have this trauma hanging over our heads at our ages. It's disgusting, to say the least. It would seem they are trying their level best to make paupers out of all of us so we shall wind up on the ward with nothing. It's too bad our government can't govern where it's most needed and not stoop to battering residents of nursing homes.

"Please families, help us fight this.

"Sincerely, Vera Nicholls."

As I say, Vera wrote that for dissemination at a meeting we held with the families and residents.

Excuse me, Mr Wessenger. Did I say something that was humorous? I noticed that you were laughing.

1040

The Chair: Please go ahead.

Mr Wessenger: Go ahead.

Mr Hayward: Thank you.

Vera's letter and her current homeless situation I think illustrate in human terms two major impacts of the pending legislation. Her words I think echo the anxiety, the frustration and the anger felt by nursing home residents and their families over this drastic hike planned in the resident copayment. We're certain that all nursing home residents in Ontario would express the same emotions if it weren't for the fact that the majority of them have cognitive or physical impairments which prevent them from being here to speak for themselves today.

Her situation is that she's in hospital, nobody knows for how long—indefinitely—with nowhere to go, and perhaps for the remainder of her life, depending on her health. We think this exemplifies the uncertain future shared by large numbers of ill, frail, elderly women and men now in hospital simply because adequate chronic care facilities just aren't available.

Continuing to reduce or freeze nursing home beds in Ontario—and we understand this is part of the redirection in Bill 101—will certainly set the stage for a human care dilemma unprecedented in this province's history. It's estimated that the number of people over age 85—and that's just the high end of the aging explosion that will be fuelled with the

eldering of the baby-boomers—is expected to grow by nearly 120% during the next decade or so.

Similar to others who have appeared before you, we do not disagree with the government's intention for increased funding for expanded community-based and home support services. Clearly, it's a laudable goal for seniors to stay at home or with families as long as practical, but not at the expense of people like Vera or the thousands of other elderly who, through no fault of their own, will find themselves facing similar anguish and uncertainty in their foreseeable futures: people like our parents and our spouses and our relatives, and, since none of us can predict what low cards life will deal us in the future, maybe even you and maybe even me.

There's no doubt that despite the improved and extended home care, the demand for special accommodation in future is going to be there. The question is, ladies and gentlemen, will there be sufficient beds to meet the demand? In terms of timing, it's the government's intention to hike up the copayment immediately upon passage of Bill 101. Already, letters advising of the increase have been received by residents, just adding to their anxiety and to their apprehension, especially for those people who say they can't afford the 45% hit.

In response to these fears, which the opposition voiced during the debate of the bill, a debate which occurred, many of you here remember, late at night and with so few government members in attendance that a quorum count had to be called three different times—perhaps it's an indication of the government's lack of receptivity to the opposition and to constructive criticism from the public—here's what the government said. We quote the Honourable Frances Lankin, the then Minister of Health:

"Each person's charge will be based on the ability to pay as determined by a simple income test. If they are getting the federal guaranteed income supplement, GIC, they have limited ability to pay. If they cannot pay the full charge or per diem, the charge will be reduced or eliminated based on the amount of GIC they receive."

How do we reconcile that statement with the other government position that those residents whose annual income is \$10,680 or more will be targets for the full increase? That \$10,680 is probably less than most of us here spend for our cars. Think about having to live on that amount for a year, and then think about having to use even more of it or have more of it taken away from you for so-called improved services when, as of today, right now, we haven't been told, nor have the residents, what those improved services are. That's the nub.

I'd like to give you a personal human example of just one person who is going to be disadvantaged by this increase. It's one of the reasons I'm here. Remember, as I said, to flash back to these images we talked about earlier.

My mother, who also lives at Guildwood, has a total annual income of \$12,300. That's it, folks; no more. The Bill 101 copayment increase will immediately cause her monthly accommodation costs to jump by approximately \$375, bringing her annual expenditure for room and board alone to \$17,789. That's about \$5,500 a year more than she brings in from her pension. You tell me how she will be

able to afford such an outrageous increase just to have a roof over her head, to say nothing about being able to buy little things like toiletries or the odd blouse or dress, or anything else that helps her to maintain her individuality or her self-sufficiency and, perhaps most importantly, her self-esteem.

My friends, something is drastically wrong with the government's plans and priorities if my mother, and a sizeable portion of the other 46,000 or so elderly men and women living in nursing homes, must, as we said earlier, suffer the consequences of this bill and the copayment increase that's embodied in it.

I'm confident that those here with me today could tell you similar stories about their relatives currently living in nursing homes. Even if they didn't, you will make your recommendations in full knowledge of the potentially devastating effect this aspect of Bill 101 will have on their loved ones and on those of your constituents who undoubtedly face the same human dilemma if the copayment increase is rammed through based on the present timing and amounts.

Speaking of amounts, if the lion's share—that's 75%. or \$150-odd million—of the government's announced \$200-odd million to improve nursing homes and homes for the aged must come from existing residents-and we don't believe it should—then it's incumbent upon you to seriously consider Mr Lumsden's detailed proposals and recommendations, particularly as they relate to the proposed residents' copayment increase. I know he has been dealing with Mr Quirt quite extensively in correspondence for the last several months on the whole issue. For those among you who do prefer to make your decisions based on hard facts and figures, you'll find plenty of them in his report. Initiatives such as graduated annual increases tied to rent controls and the consumer price index have to be analysed and given every consideration. I think the operative word is "phase-in."

If, on the other hand, you're among those who do not fully accept that 75% of this money should be drained from residents of long-term health care facilities, then you only have to look to the most recent Auditor General's report on government spending to suggest other sources of funding. For example, I understand there's \$140 million outstanding in the employers' share of OHIP fees, and there are undetermined hundreds of millions of dollars in unjustified and fraudulent welfare claims, to name just a couple. Hire a few more investigators, enforce existing laws and curtail the squandering of dollars to the undeserving. Redirect these funds to those who need the money most.

Stamp another nickel tax on to a pack of cigarettes or a bottle of booze and push some of those dollars into long-term health care. Most people will support the so-called sin taxes, but only if they're assured that the money raised is pumped directly into health care reform and not used to service the deficit or used for some other unrelated program.

Re-examine the allocation of dollars that are in the health system now. I'm told there's lots of money in the health system, and although the organization and distribution of those funds is probably a whole other issue, it's something we should be looking at.

Bill 101 seems to be the right thing to do, but in reality, Bill 101 appears to have been crafted in a vacuum. In fact, it gives rise to more questions than it answers. For example, it calls for level-of-care funding based on annual classification audits, a test of which was undertaken at considerable expense in nursing homes by the government last year. Where are the results? Where is the report? How will classification be carried out in future? Is the Alberta model—and I heard the previous speaker mention it—the best instrument to use in evaluating Ontario's needs, particularly given the differences in population, aging patterns, health delivery systems and so on that exist between the two provinces? What are the new and improved services nursing home residents will get for forking out \$150 million more with Bill 101?

How will placement coordination work? What criteria will be used for placement? Geographic? Ethnic? Or will it simply be that you go where the bed is, because available bed space will become increasingly disproportionate to need given the bed reductions and closings under way now and in the future?

1050

Where is the report on community consultation promised by government first for last year and then for January of this year? This is the report that the government is saying was the most exhaustive, comprehensive community consultation in the history of this province. It's being used to justify the passing of this bill, yet the report has not been given to the people who participated in the consultation to see what the justification is for everything embodied in Bill 101.

What else besides an extraordinary hunger for cash formed the basis of a 45% hit to our at-risk seniors? What influence have the public service unions had on the government's decision to penalize residents of private nursing homes, the majority of which provide equal if not higher levels of care in terms of quality, frequency and respect for the individual's dignity than most of the so-called not-for-profit institutions?

These and a whole host of other questions must be answered and, I think more importantly, asked by the opposition and the media in the future debate to come on this bill. Speaking of the opposition, we give full credit to the honourable member for Halton Centre, Barbara Sullivan, and the honourable member for Mississauga South, Margaret Marland, who did press for answers to these questions and others during the debate of this bill prior to second reading. Unfortunately, as I mentioned earlier, the debate took place during the late evening, somewhere between 10 o'clock and midnight, with virtually no government members available to answer them.

Ladies and gentlemen, you have the opportunity or, better stated, the obligation to evaluate all of the submissions presented to you. We again urge that you carefully consider the recommendations presented by Mr Lumsden and the council of family and community advisory boards. These recommendations make eminent sense and should be fully considered now before the bill becomes law.

As I said earlier, we're dealing with one of the most vulnerable and disadvantaged groups in our society—I'm

sure you've heard that since you started your hearings in spades—but it's a group that all of us, everybody around this table, in rapidly increasing numbers will become part of sooner or later. In future, "should have dones" and "could have dones" will be too late and too little to address the human misery that will be born out of this bill as currently proposed. The time for improving it is now.

Thank you for listening and hopefully for acting.

The Chair: Thank you very much for a very full presentation. As you noted in your brief, we did have an excellent presentation as well from Mr Lumsden when we were in Ottawa. We'll start the questions with Mrs O'Neill.

Mrs Yvonne O'Neill (Ottawa-Rideau): Thank you for giving a personal touch. I think it's very important for each of us to place an individual in our minds who may be affected by Bill 101.

I think you are one of many, particularly in the last two weeks I would say, who have presented to us that the consultation, although expressed by the government as being extensive, has not been as meaningful as many had hoped. It did not see the things they had presented translated in Bill 101 and they are now beginning to understand that completely.

I too in my remarks have continued throughout the hearings to place before the committee my concern about the placement service and what the definition of "community" is in reference to placement service, whether that be neighbourhood, ethnic or religious.

I think you are right when you're suggesting that we are really attacking the most vulnerable, people who are making in this province \$10,680, as one of your examples. This person also is subject to income tax in this province, which is not the case in other provinces. People don't know this. People don't realize the \$150 million is likely going to come from most people. The average person's income is likely around \$20,000. Is that the group we want to tackle in Bill 101 or other government legislation? I don't think so.

The term even of, "Well, this won't be touched," and the answer is, "Because there will still be the comfort allowance." I recently lost my father in January. I never talked to him about his own money as a comfort allowance. I think it's a degrading term. I'm sorry. Even people who have some dementia want to give gifts.

Mr Hayward: Sure they do.

Mrs O'Neill: They want to feel good about themselves.

I have really no questions for you other than that you have referred to the brief in Ottawa, which I think was an excellent brief. Have you got some highlights from that brief? There were many ideas presented. We're not going to get all of those included in any amendments or any regulations that we may suggest. Would you like to suggest something that you feel would zero in on your point that we could place as an amendment?

Mr Hayward: There were a few things. I don't know whether I should be the person who perhaps prioritizes them, but there are some things that came out of Jim's

brief that are just so natural to do, something as simple as, on the inspections that are going to be called for in the new bill, that the inspections be done on a constructive and collegial basis rather than an "Aha, we caught you and you're going to pay for that" kind of thing.

That seems to be the attitude now and may be the attitude in the future. He's saying it should be, "We're all in this together. We're all trying to do the best for our elderly persons," as far as this bill applies to elderly persons,—I realize that's only one part of the group affected—something as simple as the inspections being done in a collegial way rather than in a confrontational way; standardizing all the regulations; everybody playing with the same deck of cards. If you're going to be criticized across the board, then you should benefit across the board as well in terms of government benefits.

The family/community advisory boards: This could almost be saying, "You're creating a niche for yourself in it," but making the creation of such boards mandatory. I can only speak for Guildwood. I can't speak for the representatives from the other three homes—I don't know how long they've been in operation—but until Guildwood's board was formed, the only mechanism in place for the residents was the residents council. Let's not kid ourselves; some of the people on this council are limited in terms of their capability of taking on an issue or an item to address.

Vera, the lady whose letter I read, was the president of the council. She sat on our committee and was a dynamo, a person whom we welcomed. We're so sad she's in the situation that she's in now. Please don't misunderstand. I'm not saying Vera's in the situation she's in now because of this legislation, I'm not prepared to go that far, but she was upset about it to the point that she did write the letter.

I think having a mechanism like a family/community advisory board mandatory so that there is that—

Mrs O'Neill: You're not the only person who's suggested that, you might be happy to know.

Mr Hayward: Yes. I know Jim had.

Mrs O'Neill: It has been suggested really almost across the province.

Mr Hayward: These are volunteer people. There's no time for them. I'm not being paid. I'm looking after my interests. I'll be quite upfront. I know I'm going to be hitting this age bracket fairly soon. I want to make sure there's something in place for me that I can handle and not the situation my mother has right now, for example.

Mr Jackson: Bill, thank you for your brief. You've covered an awful lot of ground here.

Mr Hayward: It's a shotgun approach.

Mr Jackson: A shotgun filled with the truth none the less. First of all, I wanted to thank you for putting on the whole issue of priority and prioritizing or whatever the buzzword is and that there is money out there. To put a figure on the welfare fraud, five weeks ago the auditor, who's just down the hall, confirmed that the figure is around 10% of payouts that are either fraudulent, unnecessary or inappropriate.

Mr Hayward:~There's the whole problem.

Mr Jackson: That's about \$600 million that is spent by Ontario taxpayers unnecessarily on welfare. I just wanted to put a dollar figure on it for any of your future discussions. That came from our Provincial Auditor.

I also want to say to you that we have been concerned right from the day of the announcement of the NDP's love affair with user fees and coming up with this \$150-million figure. We have asked for the financial workup and any impact studies, which is what you spoke to, the impact of that decision, and we've asked that of this government. Perhaps I could get a short answer, Mr Chairman. This has been a request that I made of the ministry when Mr Wilson made the announcement and a request through the committee process. Do we have those financial impact studies or the financial workups for how they arrived at this user fee increase?

Mr Wessenger: I'll ask ministry staff to reply to that.

Mr Quirt: A package of that material is being prepared for the committee, along with the other material the committee has recommended that we provide. Mr Lumsden, as a matter of fact, was mailed those calculations and that material at his request, I think probably about a month ago now.

1100

Mr Hayward: I can't speak for Jim, but Jim says he has not received any of that information that justifies the rate of the hike or the source of the hike. He has not. I spoke to him last night.

Mr Jackson: Mr Chairman, Mr Quirt was present at a briefing that I participated in the day the minister stood in the House to make this announcement and that was my first question, where was your impact study and what were the implications? I had several questions on it. Mine is about a six-month standing request, the committee has a one-month standing request, and I'm delighted that Mr Lumsden may be the beneficiary of all this information ahead of the elected people in this province; none the less we're still waiting for that information.

If I may yield my last question in the short time to Mr Hayward, since you raised a dozen or so questions in your brief, would you like to raise a question directly with Mr Quirt and use that time, which I will yield to you if you'd like to raise a question for Mr Quirt or Mr Wessenger?

Mr Hayward: I think my question would just echo yours, Mr Jackson. We're looking for the data that justify the level of increase and the sourcing of the increase. Everything is being hung on this consultation report and on the classification audit that was done.

I know one was done in Guildwood. There were two nurses in there going around for a period of several days with little clipboards and pencils and watching how long it took to lift a resident's hand and how many had to be fed and the audit was done. But there's been no report since then. My question echoes yours. Where's the meat, so to speak; where's the beef?

Mr Wessenger: Thank you for your presentation. I'd just like to indicate with respect to the report I believe it's going to be out very shortly.

Mr Jackson: Mr Lumsden's already got it. Maybe we should call Mr Lumsden and have it from him.

Mr Wessenger: Perhaps I'll have staff clarify the report that will be out with respect to the classification system.

Mr Quirt: It appears that there are three reports being referred to. There's a request that was made by this committee on analysis that compared the calculations done by the Ontario Association of Non-Profit Homes and Services for Seniors with respect to copayment revenue generation with the provincial figures. That report's under preparation for the committee. It's a different report from the one requested by Mr Lumsden. Mr Lumsden received the analysis of the ability to pay of seniors over 80 years of age on the basis of individual OAS/GIS rates for the over-80 population in Ontario and the data on how \$150 million was estimated.

The third report referred to is the report that provides the results of the patient classification survey, resident classification survey conducted last fall. That report is being prepared currently. It will be shared with members of our funding focus group towards the end of March and each facility in the province will receive a package that includes its individual results and a comparison of how its individual results relate to the average results for various categories of beds across the province, residential care in charitable homes and municipal homes and extended care in charitable homes and municipal homes and nursing homes.

The Chair: Perhaps I might as the Chair request that the information that was sent to Mr Hayward be shared with the committee as well

Mr Quirt: The information was sent to Mr Lumsden in Ottawa and we'd be happy to provide a package of that information.

The Chair: I think it would just help if we could have that as well.

Mr Hayward: May I speak? The Chair: Yes, go ahead.

Mr Hayward: I'm not familiar with the information that Mr Quirt said he sent to Jim. I do have a copy of a request to Mr Quirt from Jim, dated November 25, and I could read it, where he's asked for specific information related to what you were talking about, and I have a copy of your reply, dated December 14, to him, which, in my opinion—and I could be the uneducated person here—doesn't even touch on addressing what he asked in his reply. We could be talking about two different things, Mr Quirt. I'm not trying to put the light on you; I'm just saying that it doesn't jibe with what he asked and what he got back as an answer. If anybody wants to see these or read them, they're welcome to.

Mr Wessenger: Yes.

Mr Quirt: There was a subsequent request made by Mr Lumsden. There have been telephone conversations with him, at least three meetings.

Mr Hayward: He has even tried freedom of information, I understand, to get some of this information. He's

been turned down under the FOI act to get this kind of information.

Mr Quirt: I wouldn't want to comment on his request there. I know the information he's asked from us has been provided to him without having to go through the freedom of information process and a package several inches thick went to him, I believe, in January or February.

Mr Hayward: I can't speak for Jim.

The Chair: If that information could be made available to the committee, then perhaps we can all determine what is there. Parliamentary assistant, you had another?

Mr Wessenger: Yes, I do have a question. Several groups have made presentations to this committee suggesting that assets of the individual residents should be considered in determining the obligation to make a copayment. I would like your comment on whether you think assets ought to be considered in an ability to pay.

Mr Hayward: I personally don't think they should be, but let's back up for a second. The government's position, as I understand it, is we're not going to be doing an assets test, if you will;, we're going to be doing a simple income test.

Income generated by interest from investments, savings or whatever, that's income. Is that considered income? Then it's very quickly apparent what the assets are, based on the amount of income interest or dividends that someone's being paid so it is, in effect, to some extent, an assets-based means test.

My opinion on whether a person, because he has some money he managed to put away, lifetime savings—should it be considered in what that person has to pay or should that money be used for him to enjoy the rest of his life in comfort? I have to say it should be used for his to enjoy the rest of his life in some sort of comfort and normality.

The Chair: Thank you very much, Mr Hayward. I think we could go on for some time.

Mr Havward: I'm sure we could.

The Chair: I regret, as the Chair, there are other witnesses, but we want to thank you again for your presentation and for being here this morning.

Mr Hayward: You're welcome, and also the boards at the other Extendicares.

The Chair: Right. Thank you all for coming this morning.

CATHOLIC CHILDREN'S AID SOCIETY OF METROPOLITAN TORONTO

The Chair: I then call on our next witness from the Catholic Children's Aid Society, if you'd be good enough to come forward. Welcome to the committee. Perhaps you would be good enough to introduce yourself for Hansard and then please go ahead with your presentation. I believe we have a copy of your submission.

Ms Ann Westlake: Good morning. My name is Ann Westlake. I'm the manager of long-term care at the Catholic Children's Aid Society of Metropolitan Toronto. I welcome the opportunity to be here this morning. I've come to use my voice to speak on behalf of a group of individuals who can't

speak for themselves, who can't be here and can't articulate their needs and I welcome the opportunity to do that on their behalf

I want to speak to you about a group of, at present, some 180 individuals, young adults. All of them have a variety of life circumstances, but they share three things in common: They have all been in the care of a children's aid society in Metropolitan Toronto; they all have some degree of developmental disability; and they all have long-term needs

I hope to be able to share with you today, in a simple way, a situation that has emerged over a very long period of time. The complexities of which and the feeder system that's contributed to this difficulty are quite complex, so I don't expect to be able to address it thoroughly, but hope I can leave you with an impression of how the situation has emerged and what it means for the people's lives that it affects.

As all of you know, people who have disabilities have traditionally been dealt with in our society through a process of institutionalization. They were segregated, set aside and it was a belief system of our society that, on behalf of these individuals, we were assisting them as well as their families if we were to provide them with specialized services, often set apart from the community.

Our thinking about that, the cost of institutionalization, began to change in the 1960s and 1970s until we came to determine that the cost of institutionalization in both economic and human terms was very, very high. What we saw emerge in our society was a system of community-based support services for families and individuals and as that began to happen, we began to return people to the community and we began to ask families to continue to provide care for their children with special needs.

Unfortunately, all families were not in a position to continue to do that—the availability of services, the range of services, sometimes limited families' ability to provide that care—and the options for those families became increasingly limited.

Eventually, in the case of some individuals, those families were forced to come to a children's aid society or at times were advised, at the birth of a child with special needs, to relinquish the care of that child to a children's aid society.

1110

Children's aids traditionally have only two options in the provision of services to children who come into the care of child welfare. They can place a child in a foster home, or in the 1960s, 1970s and 1980s, we've had a range of children's group homes or boarding homes that we have had available to us to provide care to children.

I want to tell you a little bit about myself, to tell you why I'm here today and how this problem has evolved for me as a professional working in this field. In the late 1970s, I entered the field of child welfare and chose to work with children who had developmental disabilities. It was my great delight and my great privilege to do so. As part of my work, I found myself working with kids in foster homes and group homes, and it was my expectation that as those children grew up, they would move on into a

system of support services that would help them live their lives as adults

That was the case in the 1970s, but as the pressure for the available resources increased over time, it became more and more difficult to move children who became adults into a system of services that would support them through adulthood. I found myself, as a front-line worker, increasingly having difficulty finding those supports for the people I had served as children and who were moving into their adult years.

I moved on in my adult years and had a variety of other opportunities to do a range of work. I found, much to my surprise, several years after having made a job change, that children whom I had served were stuck in exactly the same circumstances they had been in when I had known them as 16- and 17-year-olds. They were living in either a foster home or a group home setting that was designed to provide care for children, and there was no future prospect of their having an appropriate home, an appropriate vocational opportunity that would serve them as adults.

That's what I'm here to talk to you about today. Those young adults are increasing in number as each day passes. They have come to the doors of the child welfare agency as children. Children's aid has a mandate to serve them to the age of 18 and, in some circumstances, 21, and past that age there is no one who will provide for their care. The crisis that emerged for child welfare approximately 10 years ago resulted in them doing some advocacy on behalf of these individuals. What that resulted in was a mechanism financially that allowed for these young adults to remain in their children's placement until such time when appropriate adult services could be provided. This problem was identified 10 years ago. Many of those individuals are still in the same circumstances.

The implications of this situation are great. First of all, in human costs, what we find is that there are children with special needs and adults with special needs being served in the same residential circumstances. It compromises the needs of both groups. Foster families that had anticipated seeing the children they had raised move into adulthood are left with the burden of providing care for adults in the absence of adult services.

There are no standards to regulate the quality of care that the adults are providing in children's services. At the other end of the continuum, the residential beds that are required for children are being utilized by adults, thus creating an ever-increasing clog in the system.

Most of the residences in which these young adults are placed are operated for profit and consequently an evergrowing sum of money is being spent each year on behalf of these individuals. Essentially, last year, it's my understanding that approximately \$5 million in deficit funding was spent to maintain the status quo.

I've had an opportunity of late to speak to some of these young adults, some of whom I knew when they were children, some of whom I'm only getting to know now, and the ones who are able to talk to me are able to tell me that this isn't what they want their lives to be. They don't want to be living with children; they want to have jobs; they want to have opportunities; they want to have day

programs; and they want to have a future. At the present time, the hope of their having a future appears to be quite limited. We've known about this situation for 10 years and for 10 years we've been unable to find a systemic solution to the problem.

I'm here today to make three recommendations and to ask you to consider them. The first is that in the drafting of any legislation on long-term care, please consider this specific group of young adults as individuals who should be considered in the drafting of that legislation. They do have lifelong needs. They have a human entitlement to be considered to have those needs met.

Secondly, as part of the multi-year plan, I think this is a group that could and should be designated as a special-interest group in the implementation of the second phase of the multi-year plan. The multi-year plan is coming to the end of, I think, the first seven-year phase, and consideration is being given to planning for the next phase of that legislation. This is a group that needs special consideration. I would suggest that as in the first phase, individuals within this group could be targeted on an annual basis to receive service so that we could begin to see some movement in the system.

Thirdly, I would ask that some consideration be given so that systemically we can begin to address this difficulty at the front door. Some of the reasons this situation has come to emerge is because of a limited number of support services in the community for families that have children with special needs. Families come to children's aid societies as a last resort often to receive help when they are in crisis, and until we begin to address that need at the front door we're going to see the numbers in this group continue to increase over time.

We anticipate that over the next five years, children with special needs who are becoming adults in the care of the children's aid society will number an additional 150 people. That will put us to a level of well over 300, and if we look at the cost implications and the human implications, they're very great. I would ask you to consider how something might be done now to begin to address this problem.

I'd be happy to answer any questions you might have.

The Chair: Thank you very much for your oral presentation, as well as the document that you've left with us. I know I benefited greatly from talking to you about this issue and I'm particularly pleased that you were able to come before the committee. We'll begin the questioning with Mr Wilson.

Mr Jim Wilson (Simcoe West): Thank you for your presentation. I think you raise a number of interesting and indeed challenging points. In an attempt to find a solution, I want you to comment on my recent experience with respect to children with special needs.

There's a nursing home in my riding near Stayner called SweetBriar Lodge Nursing Home, and 47 of its 50 residents are severely developmentally handicapped children and young adults. Many of them are children with special needs. The problem we're having is that the government has built some group homes, and the theory is that many of

these children and young adults are to move into the group home setting also in the riding.

The problem we're having is that the funding isn't there for operating the group homes, although the bricks and mortar are up. Coupled with that, many families don't want their loved ones to leave the nursing home. I've been inundated with parents saying that every time some bureaucrat over in Barrie, who has never seen the resident, decides that someone has to move to a group home. In almost every case over the last two years, the parents and family have then come to me to say: "No, Joan's been there for 15 years. She wouldn't know the difference whether she's in the nursing home, which is familiar surroundings, or whether you move her." And having visited there, I think that's a fair assessment of many of the residents, in layman's terms, in crude terms, I admit.

Where do you think we should be going? You know, many of my administrators, whether they be in community living or administrators of nursing homes, very much feel that the government will, every once in a while now, shift someone from a nursing home to a group home just to keep the system lubricated. But the group homes are turning out to be so expensive. I think the cost of putting up the group homes in Stayner for eight residents was well over \$300,000, and their staff ratios are tremendously high compared to the cuts that have had to take place in the nursing home sector.

To me, not having spent a lifetime working with this, but as Health critic and having spent a long time now touring around and seeing these institutions and visiting group homes, there's got to be a happy medium. There's got to be a solution there that I haven't quite figured out, so I'd appreciate your comments on that. That's atypical, I think, of what's going on in the province.

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Ms Westlake: I'm not arrogant enough to believe I have the answer to a question like that, which is very enormous, but I can certainly offer you my comments.

Mr Jim Wilson: Anything would be a help.

Ms Westlake: It's a question that's defied the province of Ontario and indeed most of the country for some time. I think families with members who have such serious needs face a great deal of stress in trying to make decisions about the quality of their lives. We in our wisdom, 20, 30, 40 years ago, felt that institutionalization was the best way to serve people who had very complex needs. We decided 20 years later that that wasn't the way to serve people with complex needs, and I believe, now that money is in less supply than it was to provide services, that we're beginning to question again the tenets upon which we began to deinstitutionalize.

Families are afraid of change, in some instances, where a member of their family has appeared to be comfortable over a great period of time. I think it may be unsafe to assume that the individuals themselves wouldn't notice change and wouldn't know if they were in an institution or in the community. I don't feel I'm well enough informed to be able to make that assumption.

Mr Jim Wilson: Well, that's coming from the parents themselves

Ms Westlake: Yes, I understand. I think what we need to look to is a range of services for people. I appreciate that the costs are escalating increasingly and I think we need to search for alternatives that lie somewhere between a standard of care in the community that may cost in excess of \$300 or \$350 a day for people with very complicated medical needs, to an institution where the quality of care, in some instances, is less than it ought to be. I don't know what the solution is.

Clearly, I know that the dollars that need to be designated for this group of individuals are high and need to compete with a lot of other groups who have needs that are as significant, though different. I just hope we don't reach a point where we begin again to look at institutions as the answer for people who have special needs. It's too easy. We've gone back and forth in our thinking, depending on the fiscal and economic pressures that exist. I think we need to be more creative than that and I think there are ways and means by which we can be more creative.

Mr Jim Wilson: Even a number of institutional administrators would agree that there has to be a mix and probably a better mix than what we've got now, and they want us to ensure that there's flexibility, that parents have some say in this, and the residents themselves, where capable.

Mr Randy R. Hope (Chatham-Kent): As you brought forward some of the issues about multi-year plan, phase 2, I guess we call it, and long-term care initiatives, the big concern of the ministries and also of those advocates, whether they're community living or family auxiliary, is, are we going to create another gap for people to fall through? Where does long-term care play? Where does multi-year plan, phase 2, come into the joint conversation?

What we're trying to do is make sure that the gaps are not there. Your concerns have been echoed to us in Ottawa, London, Windsor. You're absolutely right. Is somebody rethinking a whole policy? I don't think so. I guess the major goal is to downsize the institutions. We have some very large institutions out there. The direction of the government is to downsize them, complying with the multi-year plan.

The big question is—and you raise a number of concerns of fiscal realities out there—how do we manage the system? You've come up with a good answer. I was waiting to hear what your answer was when my colleague opposite was asking you what the solution is. I believe that's where it's going to take the partnership—the family auxiliary, the community living group, the government and parents—to sit down and have positive conversations on how we meet the ultimate goal.

I look at some of our centres which provide a number of activities and make residents part of them, everything from swimming to working with computers, and then I take a look at some of the nursing homes and I question the actual community living that's inside that institution, making them actively a part of it.

Those concerns you raise: You're absolutely right, and I've heard it consistently throughout these hearings. How

do we put it in perspective and how do we clear it up? I believe, and I agree with you, that they ought to be part of the long-term care overall picture, hopefully when the discussion paper comes out this month, and then they ought to be more constructively involved in the phase 2 operation of the multi-year plan. Will we come up with an answer? Only if the partners put their heads together and we come up with positive ways.

Ms Westlake: I agree. I would suggest that there aren't easy formulas. People can be ghettoized in group homes that are smack dab in the middle of downtown Toronto as much as they can be in a 60- or 70-bed residence. It's a little more difficult to provide normal experiences, I think, in a setting for a large number of people that's set outside of a community, but it can happen. We do have to struggle with one another.

Mrs O'Neill: I thank you very much for coming. Others may not agree with me, but I think your presentation has been totally unique. We've had quite a bit of representation, and I'm very pleased, from the many parent groups of developmentally disabled young people in this age group of which you speak who prefer particularly the specialized developmentally disabled institutions that are now also very fragile in this whole devolution. There are a lot of things going on that make all kinds of people who are in your position, or families of or advocates for this particular group of people, very nervous and vulnerable, because actions do speak louder than words. I think of the special services at home program, which, as you know, has reached a crisis, particularly in the area of Kitchener-Waterloo, where families have actually given up their children.

Ms Westlake: Yes, to children's aids.

Mrs O'Neill: This is the most severe tragedy, to my mind.

Ms Westlake: So they've become part of this group to which I refer.

Mrs O'Neill: Exactly. The sheltered workshop cutbacks have caused a whole other set of confusion for the age group you've brought before us. I think you have brought forward, more clearly than anybody has at this level, and I've certainly spoken to many people individually—I think the case studies are very helpful; although you didn't refer to them, they're attached to your brief—that there are adults, many, many adults, in children's beds. This is a very severe problem that nobody seems to be addressing, and it's causing a total backup and it's also causing many family problems and in some cases marital breakdowns.

We know this whole problem is long term, and I hope the parliamentary assistant for Community and Social Services continues to speak as he just did, that this issue should be addressed. Unfortunately, as I say, not many people have come forward with your message.

I would ask you—and I know it's impossible for you, but certainly much less possible for me—to suggest where we could begin. Would it be in adding to the budget of special services at home? Would it be in day programs? Would it be in supporting foster parents? Where would you make your first step to show this group of what I

consider significant but vulnerable members of our communities that there is going to be something done on their behalf, something positive? Is there any one area you could suggest that we could put some moneys into and show at least a good intention? That's my concern right now, and I get at least five letters a week from individuals involved in the situations you're talking about who feel: "The rug is gone. There's no hopefulness. We're stuck and we haven't got anywhere to turn. We have aged parents," or aged foster care or care workers.

Mr Hope: MCSS has Hope.

Ms Westlake: It's a very, very difficult question and a very great dilemma and clearly I don't have a solution. I'm here to talk specifically about the needs of this group of young people who are without families, who are without care providers, who are at the mercy of staff, who hopefully are dedicated to them and committed to them.

Mrs O'Neill: And I think on the most part are very dedicated.

Ms Westlake: I believe so as well.

If I may be permitted to make just a few comments relative to what you said. I think we need to be extraordinarily diligent in trying to determine where our limited dollars are best spent. In my opinion, we have a very great obligation to attempt to support families who are providing care to their children at home. I think the dollars that have been made available to special services at home have gone a long way to prevent children from having to leave their families.

1130

The other end of the spectrum, the whole issue of the aging parent and an adult with special needs for whom they're providing care, is another issue. But I think we can hold off the time that comes when an individual needs to leave his home if we provide some supports at home.

I can give you a very poignant example from my own experience that'll suggest what I'm talking about. I think we have to look at the financial limits in the special services at home funding. We had a little boy in the care of our society who was originally from Toronto, and because he needed a very specialized resource, we needed to move him to a group home that was in eastern Ontario. His mother was very committed to him. He had very complex needs both developmentally and medically. He had to move to a group home that was north of Belleville, some great distance from Toronto. His mother was a single parent, she had another child. She wanted her son at home. She didn't have a vehicle; she got on the bus every other weekend at great expense to herself to go and see him. She didn't have the means to bring him back; sometimes we, as an agency, we're in a position to bring him back to Toronto.

What she needed was an additional \$4,000 or \$5,000 a year on top of the money she was able to receive from special services at home so that she could provide for his care. That would have meant an outlay of approximately \$15,000 a year. We, as an agency, were purchasing care on behalf of that child in a very specialized and very good group home at the cost of about \$55,000 a year. So the savings to the province of Ontario, if we had made available that funding to that

mother, would have been approximately \$40,000, not to mention the quality of life for both her and her child.

Mrs O'Neill: And the sibling.
Ms Westlake: Precisely.

Mrs O'Neill: Thank you for being so precise.

The Chair: Thank you very much for coming and speaking about a special group of people. We appreciate you taking the time to come this morning.

Ms Westlake: Thank you for the opportunity.

BENEVOLENT SOCIETY HEIDEHOF FOR THE CARE OF THE AGED

The Chair: I would now call on our last witnesses for this morning, from the Heidehof home for the aged, if they would be good enough to come forward.

The Acting Chair (Mrs Joan Fawcett): Just a quick change of chairs for a minute. Would you introduce yourselves and begin your presentation, please?

Mr Thomas Pongray: My name is Thomas Pongray, and I'm one of 12 directors of the benevolent society Heidehof in St Catharines. With me are Richard Meyer, Ferdinand Neheli and Gordon Midgley, the administrator.

I am here today on behalf of the board of Heidehof in the hope that this time you will listen to us and amend Bill 101, at least to the extent that it affects charitable homes.

In October 1991, the Ministry of Community and Social Services, the Ministry of Health and the Ministry of Citizenship jointly issued a paper entitled Redirection of Long-Term Care and Support Services in Ontario: A Public Consultation Paper. The ostensible purpose of this paper was to serve as a focus for discussion with regard to planned changes in funding and providing long-term care for senior citizens. There were proposals that we agreed with. However, one of the proposals that caused us alarm was the notion that access to homes for the aged would be regulated through a service coordination agency.

I believe that most boards of directors of charitable homes agree with us that the use of service coordination agencies to place individuals in homes for the aged would both reduce individual choice and the ability of charitable homes to maintain the particular culture and excellence in service that is the hallmark of most such homes. This is certainly true of Heidehof. But you did not listen to us, or perhaps the agency that was charged with conducting the consultation process did not have the mandate to make the changes that we requested.

I am here to tell you that Bill 101 will substantially reduce the ability of senior citizens to choose where they would like to spend their remaining years. The bill proposes the office of a regional placement coordinator. The individual, instead of applying to the institution of his or her choice, will be ground through the bureaucracy of a placement coordination office. I submit that it will be an entirely lucky coincidence if the individual ends up in the home of preference. I am absolutely convinced that, faced with the systems needs of a placement coordination office—by "systems needs" I mean the needs of the office to perpetuate itself and to guarantee the employment of its officers—the needs of the individual will have little sway,

and this at a time when the individual is at a vulnerable age, probably more easily manipulated than at any other time in his or her life.

From the point of view of the institution there will also be no choice. We will not be able to admit residents who are attracted to our institution because of our ethnic or religious values or because of our reputation for excellence. The decision by the placement coordinator will be final. We will also have no choice but to admit individuals placed by the placement coordinator's office, regardless of whether that individual would be a good fit, from our perspective, of community and culture and regardless of whether or not we would think that we had the capability to service that individual adequately.

Please also note that the bill flies in the face of some of the very comments contained in the consultation paper. Under the heading "A Renewed Vision," the consultation paper speaks of "primacy of the individual and his or her right to dignity, security and self-determination." If you want primacy of the individual, give the individual the right to choose.

The consultation paper speaks of "promotion of racial equity and respect for cultural diversity." If you want cultural diversity, permit our home to control admissions.

The paper speaks of "importance of family and community values." If you want to achieve family and community values, and by this I assume we can include shared religious and ethnic values, then give the individual the choice as to which community will best fit his or her needs.

Heidehof is proud of its reputation for excellence and service to its residents. Heidehof was established in 1972 and expanded in 1975. The complex consists of both apartments for self-sustaining individuals as well as the home for the aged. Initially, the average age of a resident in the home was much lower than it is now, but over the years the average age of admission has increased, particularly as persons who transfer from the apartments transfer at an older and older age.

To give you a picture of the Heidehof home, please consider the following statistics. Of 48 admissions to the home between January 1991 and March 1, 1993: 24, or 50%, came from the Niagara region; 13, or 27%, came from outside the region; and 11, or 23%, came from our own apartment complex within Heidehof. Of the same 48 admissions: 34, or 71%, speak German as their preferred language; 6, or 12%, speak English as their preferred language; and 8, or 17%, speak other European languages as their preferred language.

Heidehof provides a wide range of services, from community support programs, independent apartment living, dependent apartment living, residential care beds and extended care beds, all within its premises located in the heart of St Catharines. As I have said before, Heidehof enjoys a reputation of excellence with regard to care of its residents, with regard to the maintenance of its physical facilities, with regard to its recreational facilities and even with regard to its foods. I believe you can verify all of this with officers of the Ministry of Community and Social Services.

1140

I wish to refer you to what some of the families of former residents have said about Heidehof. We have a letter here from the family of Mrs Maria Barth, dated September 3, 1992:

"On behalf of the late Mrs Maria Barth, we, her family, would like to say thank you to each one of you.

"In the 10 years that our Oma Barth was with you, you have shown her genuine kindness and care and we know that she really considered herself to be zu Hause with you. This was never more obvious than when she took her fall at the beginning of August and was given the option to remain in the hospital or to go back to Heidehof and you; she said she wanted to go back home to you. Her decision at that time was and is a tribute to each one of you.

"Throughout her short illness you saw to it that she was as comfortable as possible in her shoulder brace by moving her regularly and you made sure that the doctor was notified when she was in distress, even insisting that she be taken to the hospital to receive oxygen to aid her breathing. We always hoped and trusted that she was in good hands with you; in the past few weeks you have more than proven this. You balance capability with a wonderful caring attitude, even singing hymns the night before she died. What a comfort that would have been to her.

"On the morning of our Oma's passing, you took extra care to ensure that everything was looked after. She looked so peaceful and at ease in her own bed that we felt she had only just fallen asleep. You gave her passing a great deal of dignity.

"Being able to be alone with Oma to say a final goodbye was very special. You gave her family and friends the privacy that we needed but you didn't stay too far away should we have had need of you. It was also comforting that every one of you who were able to pay your last respects that morning did so.

"Even our funeral director made us feel proud that Oma Barth had been with you. He said that you imparted so much dignity on the occasion and took such pains to arrange matters that he felt privileged to attend at the Heidehof.

"Thank you, each one of you. You are a wonderful team of nurses who we really could not have done without either within the past weeks or the past 10 years.

"Yours sincerely, the Solondz family and friends for Mrs Maria Barth, 1893-1992,"

I have another short letter here from the family of Mrs Elizabeth Schwarz, dated December 8, 1992:

"Having observed with great admiration the excellent and attentive care given our mother, Mrs Elizabeth Schwarz, by all involved since she became a resident, we, as members of her family, feel compelled to express to each and every one our most sincere thanks and appreciation.... It is of great comfort to know our loved one is in the hands of such dedicated people."

Finally, from the Olesevich family on the passing of their mother:

"We would like to express our sincere thanks and appreciation for the wonderful care provided for our mother throughout the years and especially over the last while.

Heidehof was her home for almost 10 years, and she always felt safe and comfortable there. Your kindness will always be remembered."

When Heidehof was opened in 1972, Bill Davis, then Premier of Ontario, said the following at the opening ceremonies:

"One of the priorities of our government is provision of adequate services and housing for senior citizens. We have, I think, made good progress in this area in recent years, but no matter how much a government may do, there is always scope for voluntary effort. Indeed, it is much more desirable that the community should initiate and administer as a local undertaking such projects as the Heidehof Home for the Aged. In this way, it becomes a vital and integral part of community life rather than an impersonal service administered from a distance by the anonymous arm of government."

Mr Davis said there is always scope for voluntary effort. We see Bill 101 as being nothing short of an attack on the validity of what we, the board, have tried to achieve at Heidehof in the last 20 years. The bill tells us that the job we have done for the past 20 years was not well done; an external government authority must be introduced to straighten us out; placement coordinators must be introduced to tell us who to admit. Inspectors with plenipotentiary powers and, please note, no liability whatever, will have free rein throughout our home to investigate, to question our staff, to remove records and, should we be found in breach of our service agreement, to cut off funding.

If we can no longer control admissions to our home, if we can no longer maintain the cultural distinctiveness of our home, if we are no longer in a position to continue to strive for excellence in our care, in our facilities and in our recreational programs, what reason is there for us directors to make the effort to manage our home? What incentive is there for our directors to donate their time, energies and money for fund-raising? What incentive is there for our hundreds of volunteers to donate their time to improve the quality of life for our residents?

By continuing with Bill 101 in its present form, you run the serious risk of losing much or all of the voluntary effort that for the last 20 years has made Heidehof what it is. I am sure that we are not alone in this and in fact I am sure that most charitable homes feel the same way we do.

What we ask you to do is to exempt at the very least charitable homes from the provisions of Bill 101 with regard to the appointment of placement coordinators and the appointment of inspectors. Both of these represent an unwarranted intrusion of the government into a system which runs very well right now. I believe that nothing can replace the dedication and enthusiasm of a volunteer board of directors and the wider community to which such a volunteer board has access.

If you truly wish to preserve the primacy of the individuals in this new system, allow the individuals to make the choice of where to go. If you truly believe that multiculturalism has validity in the new system, then preserve the right of charitable homes to control their admissions. If you believe that volunteer boards and volunteer workers make a significant contribution to the care of the aged,

then permit our boards of directors to exercise responsibility as we have done for the last 20 years.

Thank you. We would be pleased to answer any questions

The Acting Chair: Thank you for your presentation. We'll begin the questioning with Mr Wessenger.

Mr Wessenger: Thank you for your presentation. I'd just like to make a statement of clarification, because the concerns that you raise have been raised on many other occasions with respect to the question of consumer choice and also with respect to the question of cultural and spiritual and ethnic and linguistic concerns.

First of all, with respect to the whole question of the role of the placement coordinator, certainly the role of the placement coordinator is to enhance consumer choice, not to restrict it. It will enhance it in the sense that it will provide all the options available in all the facilities available—the community care options, the supportive housing options—and also it will not be limited geographically; it will be across the whole province. So certainly we see the placement coordinator as a great enhancement of consumer choice.

Secondly, when we have discussed the existing placement coordinators and how they work, we've heard that they have worked very well with respect to respecting cultural and ethnic and linguistic concerns. They always indicated to us when they appeared before us that they take these into account

Consequently, because of all the misunderstandings, I'd like to indicate that the government will be recommending to the committee an amendment to the bill requiring placement coordinators to take into account the preferences of the applicant, with particular attention to cultural, spiritual, ethnic and linguistic considerations, before authorizing admission to a facility.

The proposed amendment will also make it a condition of authorization that the person consent to the admission—now, this is not legally required, because a person has to consent to admission now under present law, but we're going to put it in to clarify that that's the case because there's a great deal of misunderstanding in that regard—and that the facility agree to accept the person unless the facility does not have the appropriate physical facilities or trained staff to meet the person's needs.

So I just thought at this time I would put it on the record so that it would help clarify some of the misunder-standings that have occurred out there.

The Acting Chair: Thank you, Mr Wessenger. I think that's a welcome addition.

Do you have any comments on this?

Mr Pongray: Yes. We receive many of our applications from individuals, some from within our region and some from outside the region, and I still would have a concern as to how those applications are going to be handled. We receive these applications because we do have a reputation throughout Ontario and even beyond Ontario. Now, when somebody comes to us, how will the system make sure that there will still be that consideration? We will not be able to deal with the application, so what happens?

Mr Wessenger: I could try to answer that, but I think probably Mr Quirt could give you a more comprehensive answer to that so I will ask him to reply.

1150

Mr Quirt: Take, for example, someone living in Kingston who had a particular interest in the cultural and spiritual environment your home provides. First of all, that person would be made aware of the option of application to your facility and that person in Kingston would have the choice of saying, "The Heidehof Home is the only home I'm interested in, so just submit my application there," or the person might say, "Here are the two homes and now that you've told me about them, I'd like to apply to" whichever.

What would happen then is that the placement coordinator, working with your facility in your area, would ask you to review the information concerning that resident and ask you to make an initial determination if you felt that you could adequately care for that particular prospective resident. Then the placement coordinator, working with your facility, would prioritize the needs of all those people from perhaps your local neighbourhood or from people around the province who have said that they wished to get into your facility.

It would be the placement coordinator's job to authorize admission to your facility for those people who, first of all, had expressed a particular interest in getting into your facility and, second, were in the greatest need of the services you provide.

Mr Gord Midgley: I'd just like to state for the record as well that the placement coordinator agency in Niagara region does not work for Heidehof, quite frankly. We may have 10 to 15 applications sent our way a year, of which I don't think we've accepted one, because they're not even the appropriate level of care for our home. I really think the placement coordinating agency at the present time doesn't know what Heidehof's about. They deem us to be a nursing home. We're not even a nursing home. I guess with that background I really challenge what's going to happen with the new system.

The Acting Chair: Ms Haeck, do you have a question?

Ms Christel Haeck (St Catharines-Brock): Yes. I wanted to thank Heidehof for coming. I've had a chance to tour the facility and I really invite some of the other people sitting around the room to have a look at Heidehof. It's a wonderful facility. I really can't explain it more than that. It is something that really and truly meets a whole range of needs for people in our community but obviously beyond.

For the information of my colleagues, we had a meeting within the government caucus with the Heidehof board about two weeks ago and indicated to them that we very strongly supported their position around the cultural aspects of their brief. Realizing that they in fact do support a community far beyond the Niagara Peninsula, we felt there are a number of other groups that came before us that were in a similar situation and we felt they brought forward some interesting and very important comments representing their communities.

I do echo their sentiments today and I appreciate the parliamentary assistant's comments. I hope we can address some of the concerns around placement coordination, because I realize that there are still a number of concerns out there. I appreciate the comments of the member from the ministry staff. I know there are still questions and I hope we can work those through for all concerned.

Mrs O'Neill: Gentlemen, you have brought before us what many others have and I think it has been very helpful to have the point made as often.

You did talk about the almost oppressive inspection that seems to be going to emanate from Bill 101, and one of my concerns is that it's built on a very confrontational model, even imposing sanctions, with not very many specifics about that. Could you say a little bit more about how you think things work now—and you said you felt you had the support of the Ministry of Community and Social Services—and how you see them going to be acted upon after Bill 101 is implemented?

Mr Midgley: At the present time we work with program supervisors with the Ministry of Community and Social Services and it's done in a very consultative process when they come into the building. It's really a shared responsibility, if you will, in trying to better life and quality of life for our seniors. What we see in the inspection process is almost the removal from that aspect, looking at what's happened in the nursing home sector, and it seems to me that the nursing home sector is being implanted, if you will, in this bill. That's totally unnecessary as far as I can see.

Mrs O'Neill: Okay. The other thing you brought forward was your fears about your governance and the strength or ability for yourselves to make decisions as you now do. Could you say a little bit about why you feel that will change drastically with Bill 101?

Mr Midgley: I think what's at issue is that prospective residents come to Heidehof. They know who we are before they even get into the process. They're coming to us and speaking in their German tongue. I don't know what'll happen in a placement coordination agency.

Mrs O'Neill: I'm talking about the governance, the board. You feel your board is threatened and the decisions your board will make regarding the management of the home, I guess, broader than placements, I think I'm talking about. I wonder why you feel your governance or your decision-making is so threatened in Bill 101.

Mr Pongray: At the present time we have a board of directors. Many of the members of the board have been there since the inception of Heidehof. I think it's pretty obvious to everyone who has been there that the decisions we've made over the years have been good decisions and, as Mr Midgley has mentioned, we have worked with the ministry. It is on more of a consultative basis; I think that the phrase "partners in care" has been used.

I believe under the new bill we'll no longer be partners in care; we'll just be a little appendage to the ministry that will basically mandate every little aspect of how the home is to be run. They will come in and supervise to make sure it has been done the way they mandated it and then will give us a report card to see how we're doing. Basically they'll also have control over the funding, so they'll have all the control of what is to happen. What does that leave to the board? I believe it doesn't leave very much responsibility for us.

Mrs O'Neill: You expressed it very well. I think many have brought before us that the strengths that are in places such as you, in communities such as yours, are not going to be built upon; they're going to be threatened. I think it's very important that we emphasize that the strengths that are there and the traditions and trust that have been built up are maintained. I thank you very much for emphasizing that so well this morning.

The Acting Chair: Mr Jackson.

Mr Jackson: Thomas, good to see you. Thank you. I received your personal letter. I've been on the road with this committee for some weeks now and have not been able to respond to it. However, I'm pleased that you were able to put on the public record the concerns on behalf of your residents.

First of all, we're somewhat pleased that the government has moved from, "We'll consider it," to announcing today that it'll bring forward an amendment. That's encouraging, since both opposition parties have indicated that, in the absence of that, we would be putting forward amendments. Our amendment might be different from the government's amendment, and that's the area I want to discuss with you.

First of all, let me say at the outset that I do not believe there is some sort of conspiracy to offend the mission statements of culturally based or faith-based residences for seniors. I don't believe there's a plan. However, when we consider the economics of today and we consider the framework in which the government's put this legislation, with no new expansion of beds as a cornerstone statement in this legislation, one can then see a situation where yes, a placement coordinator will be required to be culturally sensitive in the placement. However, the government has said that the primary issue and the primacy of this legislation are on a needs basis.

Clearly, the number of Ontario residents of your cultural background is not a growing number. There are lots of other seniors' groups that are growing in numbers rather quickly. So is it your concern that over the course of a decade, the cultural complexion of your service, program etc will change dramatically, because the government will say: "We just don't have applicants" or "We have applicants, but in our opinion as the placement coordinating agents, as the gatekeepers of the system, we're telling you that person's level-of-care need isn't high enough and therefore he can't go in there. We'll wait until he is an appropriate appointee and then we'll allow him to go in. But in the meantime, we've got these eight or nine other people waiting who live in the Niagara Peninsula and they must go into your facility."

Is that what you're concerned about, that the amendment I just heard doesn't change that? Perhaps the gentleman would like to comment.

Mr Pongray: To the extent that the population is changing and to the extent that we may have fewer people applying to us who are of an ethnic origin, German ethnic origin or other European origin, we're not concerned about that. That is a national phenomenon that will happen.

I think what we are concerned about is that the placement coordinator's office will have other priorities, such as you mentioned. I think it's inevitable when you have an office, such as the placement coordinator's office will be, that there will be a set of rules imposed on that, some self-imposed, some imposed externally, and they will follow those rules. Out of that will come decisions regarding the individual.

It is also customary for an office like that to put pressure on the individual and say to the individual, "Look, this is the best place for you to go." As a result of that, there will be placements which will not really reflect individual choice.

We also have the fear, as you mentioned, that we will have placements which we will be unable to accept, perhaps those who would want to come in, because we have filled up all the positions. There's also some of that, although I don't think that's our major fear.

Our major fear has more to do with this whole business of establishing a coordinator's office over which we have no control. We no longer have control over our admissions. It's bad from our perspective as an institution and we believe it's bad from the perspective of the individual.

Mr Jackson: Your previous brief, which I have a copy of, submitted by the Concerned Charitable Homes in the Niagara Region, is a very good brief which I recommend for further review by the committee. It sets out all the liabilities, which are growing, without any of the modest control you currently enjoy with your admissions.

Knowing Heidehof as a residence which offers a range of opportunities for families—it will allow for married couples to live either together or separate within the same institution—again, this legislation doesn't acknowledge or provide for that. Again, it's a warm and fuzzy statement or it may be in regulations that to the best of our ability, we'll attempt to do that.

Do you not feel that the government's amendment should recognize that seniors have the right to live with their family members? A continuum of care program, such as the one offered at Heidehof, should have the protection in legislation which will say, "We may be taking the husband at one level care, but also the wife wishes to be resident in some type of accommodation within the facility," and that they come as a team, as a family, as a couple, and are not to be divided by the impersonal placement coordinator who says, "Look, we're not looking at her needs, we're looking only at his needs." His and her needs are together. That should be in legislation. Do you feel that should also be included in the strengthening of this halfway approach of the government to meeting your needs?

Mr Pongray: Absolutely. I would agree with that. Moreover, in our institution, we have independent apartments and we make admissions from those apartments into the home for the aged. One wonders how this will be

affected by the new legislation. Will we no longer be able to admit those people because somebody else has come in between? Right now, we have a complete facility where somebody can be there. They can come in and be there with independent living and then gradually progress as they get older and be looked after. What happens now?

Mr Jackson: Thomas, that is part of why I suggested the government's amendment. The amendment that comes from the Progressive Conservative Party will not necessarily be the same, but ours will attempt to address that issue,

to ensure that those facilities, those homes such as yours that provide that continuum of access are preserved in legislation so that you are protected. Thank you very much for your presentation.

The Acting Chair: Thank you very much for coming. The committee will resume at 2 o'clock. The committee does now stand adjourned until 2 o'clock this afternoon.

The committee recessed at 1204

AFTERNOON SITTING

The committee resumed at 1406

The Chair: Good afternoon, ladies and gentlemen. Welcome to Wednesday afternoon. This is the meeting of the standing committee on social development to review Bill 101, An Act to amend certain Acts concerning Long Term Care.

ST PETER'S SENIORS' COMPREHENSIVE HEALTH ORGANIZATION

The Chair: Our first presenters this afternoon will be the representatives from St Peter's Seniors' Comprehensive Health Organization feasibility study. If they would be kind enough to come forward. Make yourselves comfortable.

Dr Leila Ryan: To the flashing red light?

The Chair: They all flash. It's handled by powers that are greater than ours. I have to keep reminding people not to touch them; all sorts kinds of incredible things may happen.

Dr Ryan: You notice how amenable we are to flashing red lights.

The Chair: We want to welcome you to the committee. If you'd be good enough to introduce yourselves for Hansard and for the committee members and then please go ahead with your presentation.

Dr Ryan: Thank you very much. Good afternoon. My name is Leila Ryan and I'm the chair of the community steering committee for the seniors' comprehensive health organization in Hamilton. With me is Sue Goble, who is the SCHO project coordinator.

I'm very pleased to be here today. For us certainly it's an opportunity to provide what we consider to be very important input into the amendments on certain acts concerning long-term care.

You have our brief in front of you, so I really don't want to repeat that. What I'd like to do is divide some fairly informal remarks into four sections. First of all, I'd like to give you a little background on our CHO site. I'd like to talk to you a little bit about a very important issue, and that is continuum of care, and then outline for you what we see to be five key problems with Bill 101, and then to conclude with some recommendations that we would like to make to you.

Before I begin on the more formal part, let me tell you a little bit about St Peter's Seniors' Comprehensive Health Organization, more commonly known as the CHO, because I'm not going to be through in 10 minutes if I don't shorten it.

Our project is one of six sites that are around the province that are investigating the CHO model. These sites have been at work for some time and have joined together in the Comprehensive Health Organization Network of Ontario, which I believe you heard from yesterday.

In the very broadest terms, CHOs take responsibility for the delivery of services for a locally defined population. This population becomes the members of the CHO. CHOs will work in partnership in the community with physicians, with acute care hospitals, with chronic hospitals, nursing homes, homes for the aged, in-home services and community services.

In 1988, which is almost five years ago now, St Peter's Hospital, which is a geriatric chronic care hospital, redeveloped its mission to focus on the senior population. Very briefly, what we did is direct our attention away from bricks and mortar and concentrate on how care was delivered instead of where care was delivered. The kind of initiatives that we took at that time were very much in keeping with the recommendations reported in the Evans, Spasoff and Podborski reports.

Armed with the knowledge of the changing health care scene and arising from its own mission, the board approved the submission of a proposal to the Ministry of Health in September 1988 seeking approval to undertake a feasibility study for a seniors' comprehensive health organization. What that meant is that our population would be defined according to age; ie, the over-65 group. We are fairly liberal in our definition of "senior."

The Chair: That was 1988? Dr Rvan: That was in 1988.

Interiections.

Dr Ryan: I forgot the forum in which I was speaking. I'll be very careful in future.

In order to move this process forward, a steering committee was established with good, solid representation from consumers, community, provider groups, institutional and medical groups, the university, the district health council and of course St Peter's Hospital. This steering committee reviewed and revised the original proposal, approval for the feasibility study was granted in the fall of 1990 and the study was formally begun in January 1991 under the direction of the steering committee. During that time, ongoing consultation was held with consumers, physicians and other providers within the community.

As well, seniors in our community have talked about their issues and concerns about the currently fragmented system, the gaps in services, and some have acknowledged that they felt that the CHO system was a way to tie all the pieces together in a way that would be beneficial to them. The over-55 age group particularly is attracted by the possibility of this notion of one-step shopping for health care. That is one umbrella organization, a CHO, which knows all about their care needs. What is additionally attractive to this age group is the opportunity to participate in the decision-making process, the kinds of decisions that surround their health and social care needs. As well, potential partners are excited about this type of organization because they see this as being efficient, effective and an innovative way to deliver care.

Certainly, for our community the community participants see that this is a way of increasing the quality of care and, as well, increasing the flexibility in the way that care is delivered.

Probably most strongly, we and our community see that the CHO is a very rational way to provide the continuum of care for our citizens. We see this issue of continuum a very major one. In the light of that, I'd like to call to your attention some remarks to this committee that the Honourable Frances Lankin made in February this year:

"What we are attempting to do is understand that there really is a continuum of care that is required, and while we have pieces of it in Ontario now, we don't have good linkages and we don't have the sense of the continuum, that people can enter and exit various points of the system at appropriate times to get the care that they require at any particular point in time."

We in the St Peter's CHO agree totally with the minister's comments. There is a compelling need for a well-coordinated approach, community by community, to help improve upon that continuum of care for people.

While the former minister has previously made a commitment to the continuum of care as embodied in the CHO system, this proposed legislation will seriously undermine a CHO's ability to provide or purchase services. Bill 101 in its current form will present real barriers to achieving a continuum of care both now and in the future. In this instance, it appears that the government has chosen a regulatory approach which is in sharp contrast to the way both the hospitals and homes for the aged are currently governed and regulated. In short, the legislation appears to put one segment of the continuum under a completely different set of rules than the others.

While we agree with the minister's five stated policy objectives for Bill 101, we are concerned with the approach that government has adopted to achieve these objectives.

I'd now like to move to the key problems we see in Bill 101.

The first concern that we have is the shift from an insurance model to a contractual one. By placing long-term care facilities into a contractual agreement, this means there will no longer be a universal, accessible approach to health care in these facilities.

This bill also appears to remove all government responsibility to fund homes equally in order to provide the same level of service to everyone across the province. Each year, the service agreement must be renewed and the government will have no obligation under the act to fund the level of care required by residents or to continue to fund programs if they choose to change the agreement. There also appears to be no arbitration or appeal mechanism in the service agreement.

We believe government must be held accountable to maintain equitable and consistent services in all long-term care facilities throughout the province.

Our second concern has to do with increased expectation regarding levels of care without the necessary resources to back up those expectations. The proposed classification system is only being used to allocate funds for nursing and personal care services. The new funding formula will not enable long-term care facilities to deliver the various levels of care as promised by government.

The requirement for a care plan is set out in the legislation. However, there does not appear to be any flexibility should the resources not be available to provide the services outlined in the care plan.

In addition, it appears also that an overemphasis on paperwork may well reduce the amount of care that can be provided to residents.

Our third concern has to do with the placement coordinator role. The government needs to explain how this position fits in with its overall plan to provide better coordination of service delivery, both in-home and in facilities. If, however, the placement coordinator is to be the new gatekeeper, this service must be available 24 hours a day, seven days a week, as many, if not the majority, of these decisions may well be made on evenings and on weekends.

More consumer choice must be written into the legislation than is presently there with respect to ethnic, linguistic, geographic and religious preferences.

We also recommend that no new level of bureaucracy be created for this position and that existing resources be used for the placement and coordination function.

Our fourth concern has to do with the inspection role and the potential adversarial situation that this may set up. We identify that the amendments which cover the area of inspection are clearly designed for a worst-case scenario. putting in place very broad powers that would result in inconsistent and really potentially quite unfair application of the sanctions and the inspection process. Accreditation, peer review and continuous quality improvement programs have in other circumstances all been deemed more effective ways to monitor and evaluate. Draconian measures tend to produce the lowest common denominator of result. Participatory mechanisms have been demonstrated to produce much better results. Accreditation, peer review and quality improvement programs, in our mind, are much more effective ways to monitor and evaluate care. As an example, CHOs are accountable for ensuring their operations and services are effective through formal quality assurance management programs.

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Our fifth concern has to do with the need for long-term care facilities to determine their own roles. These facilities must have the right to define their own admission criteria in consultation with the community, and they must be able to refuse an applicant based on a home's resources, both human and physical, and its ability to meet care needs. Facilities must have an appeal mechanism to challenge placement recommendations, and that mechanism must be a timely and efficient process.

In summary, our major concern is that these amendments to the legislation have set up a restrictive set of rules and regulations to deal with long-term care direction which are not at all in keeping with the philosophy of efficient and coordinated care.

In light of all of this, we have four recommendations, the first of which deals with governance. We recommend that the government adopt the same philosophical approach to the governance of long-term care facilities as it does to the rest of the institutional sector in the health care system.

Currently, hospitals and homes for the aged are governed by voluntary boards of directors who ultimately bear responsibility to the government and to the community for the overall fiscal integrity and management of their organizations.

At present, chronic care hospitals and nursing homes have set up community advisory boards made up of consumers, families, interested citizens and providers. St Peter's CHO will have a similar governance structure, which we believe will not only improve the quality of decision-making, but will foster increased responsibility of its members for their own health. In short, our position is that a role in governance is the best teaching tool to help citizens in this responsibility for their own health.

We believe that the new long-term care institutions should maintain similar governance structures to those currently in place in acute and chronic care hospitals and homes for the aged. Only this approach supports the continuum of care concept for the consumer.

In terms of peer review and accreditation, we fully support the concept of accountability. Accreditation, peer review and continuous quality improvement programs, as I said before, have all been deemed effective ways to monitor and evaluate care. For example, again in the CHO system, CHOs are accountable for ensuring that their operations and services are effective through formal quality assurance management programs.

In terms of equity and funding, it is time to distribute funds equitably between nursing homes and homes for the aged. However, flexibility must be given to these facilities to enable them to use their resources as effectively as possible.

We also believe that where existing placement coordinators or agencies are currently doing a good job, a new structure should not be put in place. Placement coordinators should work with all the players, home care, acute, chronic and long-term care, to establish specific admission criteria that cover the range of needs in the community.

Not all levels of care will be available in all facilities, and it is important that placement be made in accordance with patients' needs. St Peter's hospital, for example, has established a number of specialty care programs which provide care to patients based on their primary reason for admission to the hospital. People who were admitted, for example, with respiratory problems, will be placed together in one program; those who have heart disease will be placed together in another. These programs allow for more specialized care of patients, since program team members are experienced in dealing with the specific health problems, and these programs benefit both the hospital, in terms of efficiency, and patients, in terms of care.

In the CHO system, to ensure that the widest possible spectrum of services is covered, the CHO must provide a full range of vertically integrated services to its members and, as such, will be able to match the consumer need with the appropriate inpatient, outpatient or home service. These services can be directly provided by the CHO, or the CHO may arrange for existing community providers to give the care.

My final remarks are coming up right now.

Since 1988, St Peter's CHO project and other CHO communities throughout the province have devoted thousands upon thousands of volunteer hours researching the efficiency, validity and appropriateness of the CHO model to meet the needs of our people. The government has previously confirmed that the CHO health care delivery method is one that matches the philosophy and ideals of the government.

Given that this is the first in a series of legislative amendments to address long-term care, our concern is that Bill 101 as it is now written flies in the face of the government's previously stated commitments to long-term care redirection and to the CHO model. In developing a reformed long-term care system, there must be a properly structured, well-coordinated, integrated system of community and facility services which can provide the range of choice and enhance the quality of life and independence of the elderly and the disabled. We believe it is possible to redirect long-term care services to meet these principles across the variety of facilities and in-home services, while at the same time retaining the strength and the diversity of the system.

Bill 101 is the forerunner of long-term care legislation and, as such, major changes must be made to this bill to ensure that the philosophical approach used to govern long-term care facilities does not present a major barrier to providing the continuum of care for the health care consumers of today and tomorrow.

Thank you very much for the opportunity to provide our comments today. This consultation process has allowed time for us to focus on the major points of concern in the proposed An Act to amend certain Acts concerning Long Term Care in Ontario. Thank you, Mr Chairman.

The Chair: Thank you very much for coming. As you're I think aware, we had the Ontario-wide group here, and being, I think, also aware that the Rainy River organization presented before us in Thunder Bay, it probably has been for some of us an excellent crash course in CHOs and how they function. I particularly appreciate the descriptive material at the end. Finally, St Peter's reputation comes before it, so we're delighted that you were able to come here today. We'll get into questions and begin with Mrs Sullivan.

Mrs Barbara Sullivan (Halton Centre): I've discussed many of these issues onsite at St Peter's and have always been thoroughly impressed with the work that has been done at the hospital when it was totally a chronic care facility and with the kinds of initiatives that are being taken in looking at the CHO.

I want to ask a question that might be a little bit bizarre, but I think it's important with relation to this bill. If St Peter's were an operating CHO facility, providing the continuum of care that is now being looked at, where would you fit with Bill 101?

Dr Rvan: I'll give that to Sue.

Mrs Susan Goble: The CHO model has to bring under its umbrella all of the pieces within the requirements for its members. In terms of the application of Bill 101 as it is presently being written, it would disrupt the momentum of

that continuum because of some of the restraints that are being suggested in the rules and regulatory issues that are described. I think we would have some difficulty with the flow, if you will, of people, and in terms of having a fit within the governance model itself for the CHO, because the governance issues will be quite varied within the different elements that are part of the CHO.

By way of example, the acute care, the chronic hospital, the homes for the aged pieces, as they currently function, have the governance model. If Bill 101 comes in and some of those pieces which are now the homes for the aged piece have a very different requirement, it will probably disrupt and cause some degree of concern for how we might be able to smoothly participate with all of the providers being part of the CHO.

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Mrs Sullivan: One of the reasons for placing that question is that we find it difficult that this particular piece of legislation has been put before us before the entire long-term care policy document is there and before the chronic care role study is available. As a consequence, we are looking at one piece in isolation.

We know that, by example, the Perley is moving in one direction in Ottawa. You are moving in a quite different direction with an enormous amount of community input. Yet we are finding that this bill is set in isolation without appropriate linkages that are readily seen or readily available and you may in fact have to go through a completely different process again even after your study is completed and if there's action to be taken.

Dr Ryan: In terms of the Perley, the differences there are that the Perley has opted to be a long-term care facility, which puts it in a totally other ball park. It is a complication, certainly.

Mr Jim Wilson: Thank you very much for your presentation. I too, along with Mr Jackson, visited St Peter's hospital last year and learned a great deal and was very much impressed. I'm also impressed to learn of your seniors' comprehensive health organization initiative.

I want to follow on what Mrs Sullivan's just been at, because I think we write the same notes down from time to time.

Mrs Sullivan: No, he just reads mine.

Mr Jim Wilson: Mine says: "How does CHO fit into this legislation?" I have a little hard time reading that way. None the less, she raised a very good point in terms of how this whole process is becoming rather overwhelming, I think, for legislators because we are doing this in a vacuum. We're having to spend early mornings and late evenings meeting with groups, trying to fit our own pieces together to try and figure out where the government's going because we get very little help from the parliamentary assistant or from government members on this committee. I'm not sure they really know where the ministry is going. I talked with the deputy and he's concentrating on hospitals these days, so I'm not sure Mr Decter's really figuring out exactly where long-term care is going.

I want to ask you the question again about CHOs and how you feel they fit in. I understand from your response that you feel if Bill 101 goes ahead, it could complicate the mix out there. On the other hand I can see the government, when it's their turn, saying, "CHOs really complement what we're doing". It probably depends on how you view it and if we knew where the system was going, then we'd know exactly how to view it properly. I want you to just expand on your thoughts and the complications that may arise.

Secondly, you deal with a different branch of the ministry, I assume, than the institutional side that developed this institutional legislation. Have you had an opportunity to discuss your concerns with the ministry or the bureaucrats to ensure they understand that you shouldn't be left out of the whole plan?

Mrs Goble: By way of opening, I will say that the CHO projects throughout the province looking at CHO modelling communities are dealing with the CHO program which is placed within the community health branch within the Ministry of Health, so our primary liaison is with the CHO program within the Ministry of Health.

Having said that, every CHO project—and as we said to you on Monday, there are six of them—has a ministry working group which is put together on behalf of that particular CHO project, which is to bring together the members of the different branches within the ministry who have jurisdiction or direct influence with the particular CHO community. So they do vary in each different community, depending on what is the complexity and makeup of the existing services in the community. Through those forms there is an opportunity to address some of these concerns.

Again, though, at the local level, we have an opportunity through the discussions with our consumers and with our providers to determine some of the issues that come before CHOs, so this again affords us the chance at the local level through the district health council, through the provider meetings, through the consumer meetings, through those groups coming together such as around a steering committee forum, that you can have a chance to address this. There are a number of ways we can mutually talk about this.

Mr Jim Wilson: Let's just throw something at you here. In terms of what I know of CHOs—and I'm supportive of that direction—in terms of your comments with regard to how there might be a disruption in the continuum of care, given this new placement coordination, agency or otherwise, that's going in place, would a CHO expand to be the placement coordinators? You're dealing with the seniors' population anyway. Have you give any thought to that, rather than our starting a new bureaucracy in areas of the province where they don't have placement coordinators now? Would that fit into the ethos of the CHO at all? Could it?

Dr Ryan: I think we already said that where there are effective placement organizations in place, they should remain that way.

Mr Jim Wilson: But where there aren't? For instance, in my area of the province, we don't have this stuff, and I'm an hour away from Toronto. They don't have it in Metro.

Mrs Goble: I guess it also speaks to something we were asked the other day with regard to long-term care. In

some communities, particularly the more isolated rural communities, where a CHO will almost geographically encompass the population, that may be a good example of where you could expand upon it to be the provider and the overseer and the administrator, if you will, of the PCS function and long-term care.

Mr Jim Wilson: I can see that being helpful, because you have a personal relationship with the seniors you service, so you know the CHO will when it's up and running.

Mr Owens: I think Mrs Sullivan started us on a very interesting road, and I don't think her questions were bizarre at all. In terms of the CHO concept, I had the pleasure of touring the CHO in the Sault in January and was quite excited by the community-based care that's being delivered under that system.

In terms of my understanding of how a CHO functions, the CHO receives funding on a per-member basis. In your brief, in terms of the placement coordination—and you reference it in other parts of your brief—you say that if the service is not available that person will have to go outside the CHO for service. My understanding is that, for instance, a person could receive \$1,000 worth of care at your CHO during the month of January. If that person has to go outside for care and another OHIP billing is generated outside of your facility, do you lose that funding for that individual for that particular month?

Mrs Goble: I'll respond to your question. In the capitation model for the CHO, you're quite right that the CHO will receive a per-member amount each month. If the CHO is unable to provide a particular service to its member or the member falls ill while he is outside of the geographic location of that CHO, the CHO is then responsible for picking up the costs of care that was required by the individual. On a negation basis, the CHO is billed back what was spent on that care wherever it took place. The CHO doesn't lose its money for that person, but there is a cost recovery process in place so that, in other words, whoever did provide the care is not billing the government as well as the CHO, having received the amount per month for the individual.

Mr Owens: So in terms of Mr Wilson's point with respect to CHOs acting as a placement coordination system, would there have to be a member/non-member type of function, or would it be your expectation that everyone would become enrolled in your CHO, for instance, in terms of the placement coordination? I'm just trying to get a sense of how that would work in terms of maintaining the funding integrity of your organization.

Mrs Goble: The CHO is a situation where people have a right to become a member or not to become a member. If the placement coordination situation were going to be expanded upon, I think—and I have not had a discussion with the CHO program as to how this might come about—it certainly would have to be dealt with differently, on maybe a program basis or some other model, if you were to pick up that particular administrative responsibility for membership other than your CHO members.

1440

Mr Owens: In terms of your comments with respect to inspections and accreditation, we've spent some time

hearing about the proposed legislation. I get really uncomfortable about relying on accreditation and internal responsibility systems as being the sole measure of quality of care. Coming out of a health care institution where I worked for 10 years, two of which were spent with the Royal College of Physicians and Surgeon of Canada, I have an understanding of the accreditation process and what happens during that process. I don't think we need to legislate standards of excellence. I think that for managers, whether it's of a CHO or nursing homes or long-term care residences, that should be the norm.

I guess the uncomfortable feeling I'm getting, and nobody has actually come out and said it, is that there seems to be a feeling that inspectors may be doing case finding when they go and look at these homes. My experience with groups like Concerned Friends is that inspectors won't have to do case finding, because there are already enough issues within the community as it is.

I'm wondering if you have any further thoughts on that and what kinds of things you would like to see built into the legislation, if you're saying that the current language is too strenuous. How would we maintain the integrity and protect the safety of, in most cases, society's most vulnerable people within these residences?

Dr Ryan: Probably both Sue and I would like to respond to that, but my first response would be that an appropriate governance model is probably the best route to ensuring the protection. Without that kind of participatory governance model, I don't think any regulation is going to be appropriate or will work really effectively: community advisory boards, good community participation and appropriate community participation. I don't think that means everybody has to sit at every table, but mechanisms that really promote the involvement and the sense that the community's voice is heard and that both families' and clients' needs are responded to I think are far better ways of protecting them than a draconian inspection system.

The Chair: I'm sorry, Mr Owens, but I'm going to have to bring our question and answer to a close. It's the lot of the Chair to try to keep at least reasonably close to time.

I want to thank you for coming today, for your presentation and for responding to our questions. I think I should also thank you for helping us to establish that, whatever else Ms Sullivan may be, she is not bizarre.

Mr Hope: It's a matter of opinion, though.

The Chair: Oh, oh, I've opened something up here. I apologize. Thank you again for coming. I will resist the temptation to make those comments in future.

Mrs Sullivan: Mr Chairman, if I may, I think the issues that are surrounding St Peter's and the other chronic care facilities in association with Bill 101 do require some additional clarification from the parliamentary assistant and ministry officials. By example, the Perley, a chronic care facility, among others, I understand has entered into an agreement with the ministry that it will accept \$185 per day per patient for providing chronic care, without the role study being available. St Peter's, which offers chronic care services, is left in a kind of limbo situation, because it will also be offering, as part of its continuum of care, nursing

home services. There is a gap here that I think should be explained.

The Chair: Would you be looking for a written description of how those institutions are to function in their relationship with the ministry?

Mrs Sullivan: That would be useful. I think it might also be useful, if there is an opportunity, to ask some questions

The Chair: If you want to leave that with the Chair, perhaps through the subcommittee we can work out the best way of doing that.

Mrs Sullivan: Thank you.

IRENE DAS

The Chair: I next call Mrs Irene Das. Welcome to the committee. Would you be good enough to identify yourself for Hansard and for the committee and then please go ahead with your presentation? We have 15 minutes.

Mrs Irene Das: I recognize Mr Wessenger from the hospital thing that was similar to this.

Mr Wessenger: The hospital act.

Mr Jim Wilson: He's trying to forget those hearings.

Mrs Sullivan: Now, they were bizarre.

Mr Owens: You're so negative.

The Chair: Order, people.

Mrs Das: My name is Irene Das. I'm an RN with about 30 years' experience in nursing, and for the past eight years or so I have been working in a large nursing home.

Generally, I'm very pleased with the overall direction of Bill 101, dealing with charitable, municipal and private nursing homes. In particular, I appreciate the coordination and streamlining of long-term care with regard to funding, accountability and admissions process.

However, I have the opposite view to my predecessor here: I think some of the provisions do not go far enough. I hope my submissions to the standing committee on social development on Bill 101 will highlight and provide an in-depth look at the needs at residents and staff in these facilities.

As an RN, I will focus on nursing care needs primarily, as that is the reason why these people are in nursing homes. Otherwise, they could as well be in a hotel or room-and-board facilities or anything like that. It's because they do need nursing care.

Of course, to start off with meat and potatoes, the funding: It must be outlined in the act itself, I feel, that sufficient funding for nursing care will be provided and that it will be without charge to the residents. I have a list here of the current charges that people are charged in nursing homes and what the costs are.

I also feel that, apart from the sufficient staffing levels, a proper mix in staffing is required, as that is very important. Otherwise, if you just withhold funding because people are not getting adequate care, the thing is just going to get worse, and those who suffer will be the residents and the staff, particularly the RNs, because they are accountable under the College of Nurses of Ontario. No matter what, even if there are detrimental circumstances beyond

their control, they are held accountable and liable. Therefore, the home and the whole management must be made to accept responsibility by a system of accountability. I don't know how that works. I don't have enough experience in that area and I haven't thought about it enough, but maybe other people have the skill.

With regard to care plans, I think there should be the following changes made, or I have a few suggestions anyway: It should outline that it at least contains medical services, nursing services, nutritional services, rehabilitation, recreation, social work, pastoral services, and others can be added when needed or when they arise.

I feel that the resident and the family should be involved in the planning of care when at all possible. If there's nobody there or they are not capable of making decisions, then it's a different story. But the same thing is true for quality assurance, and I think you also should have all these things on quality assurance, plus, if you are inspecting accommodation, monitor safety, maintenance and cleanliness, pest control, these sorts of things. These are just very down-to-earth things.

Clear policies and procedures in these homes must be established regarding care plans and quality assurance plans, otherwise how are you going be able to inspect it and follow up on it? As far as quality assurance, I think it is not enough that we just base it on accreditation and peer review. For example, the College of Nurses has a thing called individual employee performance appraisals and they can be quite biased too.

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I think there has to be a continuum so that management is appraised. They have to continuously try to do their best and the staff as well. Otherwise, what you're going to get is that the people at the lower rung of the ladder who have no control over the situation are going to be blamed for everything. Homes like that quite frequently are run very poorly. I guess they don't have highly paid executives running them.

Mr Owens: Most homes do.

Mrs Das: They do?

What happens is that they start witch-hunting and then they fire a few people who they feel caused the problem. Then they look good at the next inspection and they try afresh the same game, and when there are major problems happening, the same thing happens. This went on for eight years that I know of, until we got very capable people. For the past few years we've had very capable people running the home, but I don't want to say anything about the owner. That's a different story.

I'm going to repeat myself a little bit here about what the people from St Peter's said. I also feel that care plans and quality assurance plans alone are not going to do the trick, because if they're just going to add paperwork, they're going to take particularly the RNs away from the residents. They will have less control of the situation than they had before, because so much time is expended. People take these papers home and work on them and everything. It's just a bad situation.

Of course, we know there are many reasons why elderly people live longer and that they are sicker and have a lot of problems, physical, mental and so on. These people generally don't get much better, but at some point they start to decline. In addition, the uprooting from their homes leads to a lot of problems initially until they have settled into these homes. All of this can lead to a lot of frustration, unhappiness and disturbed behaviour in the elderly. Of course, that also takes a lot of care just to settle them down. So generally, the people we see nowadays in nursing homes require far more care than 10 or 15 years ago.

I have here a copy of a survey the ministry was sending around to ask the staff nurses what the staffing levels are at the present—I don't know if you're aware of it—and what we think should be done and the acuity levels of the different residents. I think they have five or six points you can grade them at. So I'm very pleased with that. However, I think we really got very, very little time. Also, it's such a hushed-up situation where you really have to be scared that your employer doesn't find out about it and that you don't get fired or something. I'll give you my own example in private. At present I have no job.

Employers naturally try to cut costs and as a result we see highly skilled RNs replaced with more junior ones and RNAs and so on. Then what happens is that the RNs can't keep track any more of what's going on with the residents. Since they coordinate everything, all the needs of the residents-dietary, elimination, activity, whatever-they can easily miss something that's happening to a resident and it gets out of control. So I think if you cut highly skilled nursing care and replace it with unskilled or lower-skilled levels or less experienced nurses, ultimately you're going to have higher costs. I'll give you some examples. If the problems get out of hand and they're not detected in the early stages, the residents can become really sick and then they end up going to hospital or becoming very ill, and all of that is costly. It can even lead to death. It can go so rapidly with the elderly, but it's also costly to the government and the taxpaver, and that will also come out in my examples, because frequent needless use of ambulances, paramedics, hospital emergency services and so on are far more expensive than preventive nursing care, anywhere, even in the nursing home or in the homes of these residents.

I don't know if I shall upset your stomach with some of these examples, but you have them written. For example, a resident could have a cold or congestive heart failure, and eventually these symptoms are very similar, but you really have to know a lot about these types of things. So the residents start declining and get worse and worse and worse, and quite often the frail elderly just crash. Their whole system just gives in, and quite often literally they just fall on to the floor, because they sit on a chair or wherever they are, and they can sustain a hip fracture, head injury or anything. Then 911 is called and the resident goes into a hospital. When they come back, most frequently they never regain their previous independence and they end up in a wheelchair. They require so much care.

The same happens with other very common things, like bladder infections and bowel problems. They're simple things, but you have to know how to prevent these sorts of things, and of course we do more complex nursing care as well. I have it in the written report.

In summary, what I think needs to happen is that you find a way, you who are the experts, of writing this legislation in such a way that we have three things: good systems in place to check and organize the situation, their enforcement and adequate funding.

In closing, I'd just like to say that I have a special love and concern for the frail senior citizens and I hope the government will make it possible to give better care and make these people feel valued and wanted in their last days.

I want to thank you, Mr Beer, and everyone on the committee, for having me here. I hope I was of some use to you, even though it might have been boring.

The Chair: Thank you. At committee we know that various organizations are going to come forward and we're glad they do. I think we always hope we will get more individual citizens who have an interest in the subject at issue who will come forward and provide us with their experience, so we're delighted you came. We're a little tight on time, but I'm going to allow one question from each caucus, beginning with Mr Wilson.

Mr Jim Wilson: Thank you, ma'am, for coming forward and showing the courage to come forward and share your experience with our committee. I suggest that, if your employer wrongfully dismissed you because you have shown the conviction of your beliefs, you work with your local member of provincial Parliament to seek justice there. We have the toughest laws in the world with regard to that.

Mrs Das: The nurses' union is involved. It is hard to prove.

Mr Jim Wilson: It is hard to prove, but your MPP should be pretty good at it.

Mr Hope: The legislation's not here to protect the worker of that nature.

Mr Jim Wilson: Well, I deal with this. Are we having a cross-debate here, Mr Hope? That's the responsibility of the MPP. If you can't do your responsibility, don't bother putting it on the record.

Mr Hope: No, no, don't mislead somebody. You're misleading an individual.

Interjections.

The Chair: Order, please. Mr Wilson has the floor.

Mr Jim Wilson: Sorry, I didn't think that was all that contentious. I just thought it was part of an MPP's daily routine to deal with such matters.

Mr Hope: Don't mislead her.

The Chair: Please.

Mr Jim Wilson: I want to get a feel for what your experience has been and the lay of the land out there now in terms of, you talk about the reduction in RNs that's been taking place.

Mrs Das: Reduction in all staff levels. At the moment, some nursing homes have been cutting health care aide and RNA hours as well, which affects us indirectly, but it affects the residents very directly. I think private homes are

trying to get the government to cough up some more money for them.

Mr Jim Wilson: That's what I was going to ask. Is it just that the owners of these homes want to cut staff or is it that they're budget cuts, because it's happening in the charitable home and homes for the aged sector.

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Mrs Das: I don't know exactly, but I've heard something about their trying to—they did it once before in October, when there was a big demonstration and everything. They were cutting health care aide hours and other staff hours in order to blackmail the government or something like that. I'm not too sure of that. This is the rumour.

Mr Jim Wilson: Is that what nurses believe? Is that the scuttlebutt on the street?

Mrs Das: Most of them have no idea, but I've heard rumours.

Mr Owens: I am pleased that you're here today. It gives the committee an opportunity to speak to somebody who has the experience from the floor. I'm pleased to hear that ONA is working through your grievance; I assume it's ONA.

In terms of some of the issues that I've dealt with in my own riding, with RNs coming to see me about some of the stuff going on in nursing homes in my riding—

Mrs Das: You see, I was too loyal and I always gave the management time to correct whatever problems there may have been, and they have been very good. This whole thing—my own case—came out of the blue.

Mr Owens: This is the point I was going to make. Not one of those individuals has ever stated that she is complaining about the hours or the amount of money she's paid. Every time they've come to see me about something, it's been about care of the residents in the home. Again, you hit the nail on the head. In terms of the previous presentation and my discomfort around quality assurance and accreditation, the bottom line is that it's the front-line staff who get nailed with things. Once the inspector comes through, there's very little accountability for management practices and the failure to implement proper practices.

Mrs Das: Can I say something? I think I'm misreading it, but it's in there. I feel that the required staffing level should be posted in the home so that the staff know it and the residents and their families know it.

Mr Owens: That's right.

Mrs Das: That type of thing, something in that direction.

Mr Owens: I know that ONA has attempted to launch some professional responsibility grievances, because it feels that strongly about the quality of care residents are receiving. As a matter of fact, the Canadian Union of Public Employees presented a brief to us the other day. I'm not sure if this is going to make you happy or bolster your case, but it did an analysis of form 7's submitted to the Ministry of Health. They looked at the issues around the expenditures on continence care products, medical and nursing supplies, raw food costs, dietary supplies and services, housekeeping supplies and services and laundry and linen

supplies and services. On an average per diem basis, the brief says the non-profit nursing homes spent 37.3% more than for-profits on these resident care items in 1990, and in 1991 the non-profit homes spent a full 42.2% more on these products and services.

Mrs Sullivan: What about raw food costs?

Mr Owens: You asked a question about where the money is going. There's a pretty clear indication about where the money is not going.

Mrs Sullivan: The bottom line is the difference of wet and dry diapers, cloth versus paper.

The Chair: Order, please. Let the witness answer the question. Please go ahead.

Mrs Das: What was the question exactly, in a nutshell? I got lost.

Mr Owens: There was so much howling and whining coming from the other side, I wasn't able to finish my question. You asked the question about where is this money going, and I think that my question is, more importantly, where is this money not going?

Mrs Das: Exactly. I think somehow it would be good to have of safeguards so that there is accountability at least in the areas that affect nursing care. Of course, I'm also concerned about the food and all these things. That's very important.

Mr Owens: Curare for Jim Wilson.

Mrs O'Neill: I just wanted you to go to one of your own statements, if you would. You've talked about the quality assurance plans, you've talked about posting the staffing levels and you've talked about assurances and worries you have. Then, on the other hand, you say that the quality of care will diminish and you'll have added paperwork.

How do you see Bill 101, or whatever we want to call quality assurance, being enforced? At the same time, what I see here are some accountability mechanisms not being in place. Do you want to say a little bit about how you see Bill 101?

Mrs Das: Yes. I think things like that should be in standard form with a lot of things pre-printed and then you just add your comments so that you don't have to rewrite all these stories. For example, if you have a care plan, you should have down, you know, different things: skin, this, that and the other, whatever can go wrong.

Mrs O'Neill: What makes you think it's going to be so different?

Mrs Das: We have some types of care plans now that are far simpler than they used to be in the past, at least parts of them. I think some things should be worked out in that area. Because I worked in the community as well, when I used to go with the VON, and I got down to a system which I made myself, and we had a form as well. I kept saying: "Okay. I'll ask these, these and these questions, and in order to get through these questions faster, I will rephrase them so that people just have to say yes or no or whatever." I think something like that should be done.

I'm a big believer in these forms being as pre-digested as possible so that you don't spend time writing pages and

pages of stuff. These days, the classifications already have a system that has number 1, 2, 3 and 4. I didn't do classifications very much because I worked nights, but I went to the education on it and I have the material at home. If something is pre-printed and pre-organized, it makes it easier, but then, of course, still you need enough staff. You can't have all of this in order to excuse yourself so you will look nice because all your quality assurance plans and everything are in place. The girls might have taken it home to work on it, but then they don't have any time for the residents and they are run down. Something like that helps you.

The Chair: Thank you very much. I regret that our time has come to a close, but I again want to thank you very much for coming before the committee and for providing us with your presentation and also the examples you set out in you brief. Thank you again.

Mrs Das: I have a few questions too, but I don't want to keep you.

The Chair: I am awfully sorry.

Mrs Das: They will probably be answered eventually.

The Chair: If there are any other things, please feel free to send them through the Chair.

Mr Jim Wilson: Could I just ask the witness for a copy of the list. You have a list of charges to residents in nursing homes?

Mrs Das: Yes.

Mr Jim Wilson: Could you give that to the clerk, and he can provide that.

The Chair: We could make a copy of that certainly.

Mrs Das: The ministry put that out.

COLEMAN HEALTH CARE CENTRE

The Chair: I will now call the representatives from the Coleman Health Care Centre. As they come forward, I remind honourable members that we are running a little bit late. If questions could be sharp and succinct, the Chair would be most pleased.

Mrs O'Neill: We were promised a document draft too yesterday. Is it going to be forthcoming in the next while? I mean, tomorrow is Thursday.

The Chair: It is being sent to our offices, and I will check, as we sit here, whether it has arrived. It was being sent directly to our offices, and we'll check that out and see where it is.

Mrs O'Neill: Thank you.

The Chair: Welcome to the committee. If you would be good enough to introduce yourselves, then please go ahead with your presentation. We have a copy of your brief in front of us.

Mrs Deborah Wall-Armstrong: My name is Deborah Wall-Armstrong. I'm the owner-representative for the Coleman Health Care Centre in Barrie. With me today is the home's administrator, Françoise Bouchard; she's also our former director of care. We are one of 290 members of the Ontario Nursing Home Association. Those homes, with their 28,000 residents, represent over half of the long-term care facility residents in Ontario.

As a front-line provider in long-term care, the Coleman Health Care Centre is pleased to see the government moving ahead with legislation to more equitably fund long-term care facilities such as nursing homes, homes for the aged and the chronic care hospitals in the province. It is of some concern to us that the timing is somewhat slowed down, given the fact that nursing homes have been in a funding crisis situation now for several years.

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Our particular home is a 110-bed nursing home facility located in the city of Barrie. Our residents consist of 56 homes for special care residents and 54 extended care residents, and we employ an average of 105 to 110 employees in the facility. We've been operating at our present location since 1981, and the home has a reputation for quality care. It has been given a three-year accreditation reflective of that quality care despite ongoing difficulties in managing two distinctly different populations within the home. We're also considered a teaching facility associated with Georgian College in Barrie.

We're painfully aware in the last several years of our own individual financial struggling, that if we have any hope of trying to maintain the kind of quality care that we have been providing, long-term care reform has to come in. Historically, our home, as a member of the Ontario Nursing Home Association, has backed seniors in seeking fairness for funding in the long-term care area and in ending illogical and discriminatory funding practices in the provision of that care.

We believe that this bill, when passed, would help to end what I had called the Russian roulette for seniors who find themselves, more by happenstance than by planning, placed in long-term care facilities that can be funded as much as 50% below another facility in their own area for the same levels of care.

I am also aware that the Ontario Nursing Home Association has presented a brief to you and has outlined several key recommendations. I've listed those in our paper, but in our short time today we can't hope to cover again and indicate all of those issues. But we do want to express our wholehearted support of them. What we want to do today is to highlight, through our own experience, the concerns in the placement coordination function envisaged in the act.

Our facility has a dual population, currently, of developmentally delayed adults along with extended care or senior population. We have for years had to deal with the difficulties of two very different groups. We often refer to it as caring for twins with different needs. As groups they don't lend themselves to significant integration, and until we finally achieved a three-year accreditation in 1986, we had been told previously by surveyors that it would be impossible for us, with our dual population, to meet standards necessary for the three-year accreditation in the quality of the environment in our home.

With considerable effort, staff commitment and cost, we have met the challenge. But doing that exercise and having done that, we recognize that at the present time it's becoming harder and harder for us to continue to sustain that. We have had to actually implement a definitive mission statement

focusing on evolving our home into a homogeneous environment for all the residents in order for us to continue to provide on a long-term basis, we feel, quality care.

It's against the backdrop of that experience that we wish to comment on the bill's establishment of a placement coordinator and the lack of an appeal mechanism to challenge placement recommendations for facilities. Mrs Bouchard is going to outline some of our main concerns.

Mrs Françoise Bouchard: When a vacancy becomes available and candidates are considered for admission, our primary focus is the 109 residents already in our care, the capabilities of the staff in our employ and our physical plant.

The majority of our admissions come via the discharge planning officers in our community hospital. We acknowledge the fact that the discharge planners are under a lot of pressure to place the candidate anywhere they can. Their focus is not the 109 existing residents in our facility but the one candidate they have to place.

We are concerned that in Bill 101, the placement people will similarly be under pressure to place the candidate, without any counterbalancing pressure to ensure a good fit with the current facility residents and staff. An appeal process for facilities that allows them to object to placements would provide some of that counterbalancing pressure. The appeal process should recognize that facilities must be given the right to match potential residents with its own mission, services and programs to ensure quality care and quality of life for each of its residents.

We are also concerned that further movement after initial placement be looked at. Consider this scenario: The facility admits a resident whose profile does not indicate any behavioural challenges. Shortly after admission, the resident becomes both physically and verbally abusive towards residents and staff. Within a short time, it becomes obvious that the facility will be unable to meet the care needs of this resident. Also, the quality of life for the other residents and staff has become seriously jeopardized. In this situation—and I assure you it is not an uncommon scenario—will the placement coordinator be required, in a timely and efficient manner, to review such a placement that became inappropriate?

For the majority of our residents, this will be their last home. We continually strive to provide all residents with an environment that will enable them to maximize their potential and be the best they can be. In order to achieve this, we must have a mechanism to challenge placement recommendations without the fear of sanctions being imposed.

I believe the Ontario Nursing Home Association presentation indicated to you one of the shortfalls, we feel, that will take place with economic sanctions is its impact initially on residents and staff, and it should only be used as a final resort.

Mrs Wall-Armstrong: In summation, we also wanted to indicate that we have concern that the bill leaves too many issues to regulations. I think that may be part of the problem with the process at times. It provides considerable power to government and its inspectors without requiring corresponding measure of accountability. The bill holds facilities accountable for providing all residents' needs without

ensuring that funding will be provided to make this possible. Our historic experience in the nursing home sector has been that this is a sure-fire formula for failure, and we do not want this reform to fail before it gets started.

The seniors' lawsuit backed by the Ontario Nursing Home Association members showed that there has been a discrepancy and an unfairness in funding for more than a decade. The residents in our nursing homes have waited too long for the discrimination to end. A resident's average stay in a nursing home is usually just a little over three years. Many residents, based on that statistic, who were in nursing homes when the government started the process to long-term care reform will not be alive to see it implemented even if it goes forward this year. We need and must have long-term care reform carried out in a swift, logical and caring fashion or we all will inherit as future residents of those same facilities our mistakes and their resulting misery.

Thank you for inviting us today, and if there are any questions—

The Chair: Thank you for coming for your presentation. We'll move right to questions. We'll begin with the member from Barrie, Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. I certainly know you're doing an excellent job of meeting the challenge of operating a dual-purpose facility. I know that is a challenge for you and I note your mission statement of eventually moving to a single-purpose facility, I think, which is probably the best in the long run if and when it's achievable.

Mrs Wall-Armstrong: I think it's also consistent with other government policy in regard to the placement for developmentally disabled.

Mr Wessenger: Yes. I note your comments too with respect to providing more clarity in the legislation and not in the regulations. I just thought I'd indicate that today I indicated to another group that there will be an amendment to the legislation to specifically put in the grounds for refusal to accept a resident. Those grounds, in general terms, will be where the facility doesn't have the physical structure or the staff appropriate for the resident. That has certainly been recognized, and we appreciate it being brought to our attention. Also, some of the other concerns we certainly hope to try to address. I would like to thank you again.

Mrs Sullivan: I'm interested in the issues you raise with respect to the requirement of the nursing home to accept a resident and the power of the placement coordinator in that. Under the current regulations, regulation 43 says:

"Where the physical or mental condition of a person is such that, in the opinion of his or her physician or the director, the person cannot be properly cared for in a nursing home, the person shall not be admitted to a nursing home or remain as a resident."

Regulation 56 says:

"Every resident shall be given nursing care in accordance with his or her needs, and the care shall be given under the supervision of a registered nurse" and so on.

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I think these are key issues, particularly when we're talking about developing a plan of care. The plan of care is envisaged to be done once a year, which the current regulations provide for, but the funding is done on a per-bed basis. If the plan of care, now that you will have to accept people whose acuity is greater—indeed, where the manual indicates that procedures for oxygen therapy, intravenous therapy and in-dwelling catheter care may not be required of a home, under the new rules they will be required. How are you going to deal with this in terms of funding if once again you're only dealing with a plan of care once a year, when the acuity of the resident is such that you may not be able to provide those services?

Mrs Wall-Armstrong: I think from a practical standpoint, initially we had been given indications that if somebody needed an IV or had an in-dwelling catheter and we did not have staff, we wouldn't be forced to accept them until our staff had had training. But how long that will be or whether—that's the only comment that's been made to us on it, but currently we probably don't have staff that would be trained in those aspects yet. A lot of the RNs in the nursing home haven't had that training or, if they've had it, it's been quite a while since they've had it and they would need upgrading in that training. So there is an issue. It would be an ongoing issue in terms of education for them

We are on an ongoing basis updating plans, even though they may only indicate a requirement of once a year. I think that's why we pointed it out. People don't remain static for a year at a time. There needs to be a process, because even right now we have difficulty, when we have a resident who is not suitable for a nursing home, in finding other placement. Even though the legislation may say they're not to remain in a nursing home, if there isn't another proper placement for them to go to, they still remain.

Mrs Sullivan: That's right. This is an issue that we're very concerned with, and I expect we will be bringing forward an amendment that will make it clear in the legislation that if a home is unable to deal with the care needs of the patient, whether because of staff training or physical accommodation elements and so on, that will be taken into account. I think it has to be spelled out in the legislation and not just in a manual or in regs.

Mrs Wall-Armstrong: I think so too. One of the reasons we stressed the need for an appeal process for the home is that we recognize, from watching placement coordinators right now in other facilities, how much pressure is on them to put that person in a placement. I don't see, without the balance of an appeal process by the facility, which is looking at its own specific environment and its own residents, where there can be protection for its existing residents against that pressure. There is a lot of pressure out there for placement people to put them in.

We have a very good relationship with the hospital. We know they're under constant pressure on placement. They know what our criteria are, but on a regular basis we are asked to accept people they know full well we're not capable of accepting. They're under that much pressure that, "Well, we've got to try." We're concerned that without some balance, the concerns of our existing residents won't be met. There won't be anybody to stand up for them and say: "No, this doesn't suit. You can't have somebody coming in here who's going to be disturbing all these people who are currently here."

The Chair: Mr Wilson.

Mr Jim Wilson: Thank you very much. As the member whose riding abuts Barrie, I'm very often in Barrie and I know of the good work you do at the health care centre.

Very quickly, we just discussed again the points you raised concerning pre-admission and inappropriate placements, but you also raise a very good point on page 3 of your brief: What happens if a placement becomes inappropriate after they're in the home? Given that most of this is left up to regulations and we don't know the answer to that, I'll ask the parliamentary assistant to clarify that matter. Is there an appeal or a mechanism to be put in place that would allow a facility to review an inappropriate placement?

Mr Wessenger: I will ask ministry staff to indicate the procedure through the placement coordination.

Mr Quirt: There currently is a provision in the bill that allows facilities to reject an applicant based on the reasons defined in regulations. As Mr Wessenger said this morning, he would be prepared to move an amendment to the bill that would provide a couple of examples, the example of a facility having a right to refuse an admission if there was no one in the facility with the appropriate training to meet the particular care requirements of a resident or if the facility was not designed appropriately to accommodate the resident.

Mr Jim Wilson: I'm aware of those, but my reading of the English language indicates that that's a pre-admission rejection; the person isn't physically in the home. This is reading the form from the placement coordinator, and the home has an opportunity at that point. What if someone becomes inappropriate after placement? Is there a procedure in place?

Mr Quirt: There's no procedure in place now, other than that the facility is required to seek out an appropriate alternative accommodation for that resident and to make application, involving the family and the resident's physician, to a more appropriate care setting, perhaps a private hospital.

Mr Jim Wilson: So under the new system, the facility would have to go back to the placement coordinator and ask to be—

Mr Quirt: Under the new system, the facility would indicate to the placement coordinator that the resident's condition has changed, the resident now requires a service that it's unable to provide, and ask the placement coordinator to seek out a more appropriate placement.

In the case of a quick change in the needs of the resident, an emergency situation, the physician would be able to admit that resident to hospital, and that often happens now. For example, if a resident requires a particular treatment that's not available in the nursing home, then the staff

at the facility and the physician would make arrangements for that transfer in an emergency situation.

Mr Jim Wilson: Do the witnesses want to comment on that at all?

Mrs Bouchard: It has been our experience several times in the 11 years I've been with the facility that when a resident is admitted, for whatever reason, we're not given a complete profile, or that following admission, again for a variety of reasons, the resident is unable to adjust to the environment, and we've tried to seek help to have this person appropriately placed.

In one particular incident where the resident was physically abusive towards both staff and residents, it took 18 months to try and work something out and get some kind of assistance and be able to prove—not to the family because the family was very empathetic with our situation, very distraught—that in fact this person was not appropriately placed and was jeopardizing not only all the other residents but all of our staff. But it took 18 months.

Then when it came time to arrange something, they wanted to talk a swap. We weren't interested in talking about a swap. We wanted to make sure that this person's care needs would be appropriately met and at the same time that we could carry on with our lives and look after the people the way we should be.

Mr Wessenger: I believe staff would like to add further clarification.

Mr Quirt: Clearly, there is a problem in trying to find an appropriate alternative placement for a resident who moves into a facility and whose behaviour changes and presents a danger to himself or herself or staff or others.

Mrs Bouchard: It's almost like we need a probationary period, whether three months or six months, like we do for employment, where, say, in six months you review this person and how the adjustment has gone and whether in fact that person is a good fit and if we can meet their care needs.

Mr Quirt: In half the province, currently, staff and the facility would be left to their own devices to find an appropriate alternative placement. With the advent of a placement coordination system province-wide, there would be someone else to help with that difficult problem of finding either the resources to help the facility cope with the problem or a more appropriate placement.

I would also add that under the proposed placement process, once an applicant has expressed a preference for a particular facility and has made application to that facility, we would expect the facility to do a preliminary review of that applicant's situation and indicate whether you felt at that point in time you could adequately care for the resident.

Then it may take three or four months for that person's turn to come up for admission to the facility of their choice, and at that second point, the facility would also have the opportunity to review the resident's situation to see if things had changed and to reassess whether it felt it could appropriately care for the resident.

The Chair: Thank you. I'm afraid we're running very late and I'm going to have to play heavy here and end this

particular part of the afternoon's proceedings, but I want to thank you very much for coming before the committee. You have obviously raised a number of issues and questions of interest to the members. We thank you for coming from Barrie this afternoon.

Mrs Bouchard: Thank you.
The Chair: Merci beaucoup.
1530

Mrs Sullivan: Mr Chairman, could we have a clarification from the ministry representatives, who have now indicated that there is an additional role for the placement coordinator on transfer: finding other appropriate services for the resident which are associated beyond placement of the resident in another facility. Where is that written down?

The Chair: Can we be fairly brief about this? I'll ask Mr Quirt to comment.

Mr Quirt: Placement coordination services, in their current role, are aware of other consultative resources that may be available to assess the appropriate requirements of a resident. For example, the regional geriatric program in Metro would of course receive referrals from a placement coordinator. Under the mature system proposed in the redirection, the placement coordination function would be with the multiservice agency, which would not only organize placement but would have the resources in-house to support people in the community and in a facility setting.

ST JOSEPH'S VILLA

The Chair: I would now like to call the representatives from St Joseph's Villa. I remind members of the committee that we are now running a half-hour late, if we could keep that in mind as we proceed. Welcome to the committee. If you would be good enough to introduce yourselves, please proceed with your presentation.

Mrs Barbara Mahaffy: Thank you very much. I'm Barbara Mahaffy, director of finance at St Joseph's Villa. With me this afternoon is Gerry Malcolmson. Mr Malcolmson is a member of the board of trustees at St Joseph's Villa and is also chair of the board's public relations committee.

We certainly appreciate the opportunity to appear before the standing committee this afternoon. The major purpose of our presentation is to encourage the standing committee and the government to move forward without any further delays to implement this long overdue and important piece of legislation.

While in our presentation we will comment on some significant areas of concern and on some recommended changes, I cannot overemphasize the urgency to the seniors in our facility, the seniors in the Hamilton-Wentworth community and their families, that the inequities in the current legislation and current funding system be corrected.

St Joseph's Villa is a 370-bed charitable home for the aged located in the town of Dundas. The catchment area for both seniors and their families who currently use our services covers the following geographical areas: Hamilton-Wentworth region, portions of Brant county and portions of the regional municipality of Halton. These seniors and their families come from the following ridings: Wentworth

North, Wentworth East, Brantford, Brant-Haldimand, Hamilton Centre, Hamilton East, Hamilton Mountain, Hamilton West, Halton, Burlington and Oakville South.

In addition to our home for the aged, we currently assist seniors to remain in the community through the provision of the SJV Senior Centre, which provides services to 103 seniors through a six-days-a-week seniors' day centre. The St Joseph's Villa respite care program is a six-bed service through which we provide a much-needed break for family members or spouses who are caring for frail elderly family members in their home.

St Joseph's Villa is the largest freestanding charitable home for the aged in the province. For the past eight years the seniors in our facility have been disadvantaged as a result of significant inequities in the current legislation and funding system. As a long-term care facility in the province of Ontario, we have the highest number of residents qualifying for and receiving care which the province has refused to fund. Since 1985 a succession of ministers of Community and Social Services has used the excuse of a new reformed or redirected system on funding long-term care as a reason for not correcting the significant underservicing to our residents in comparison to the residents in other parts of province of Ontario.

We believe it is time to get on with the new legislation. In addition, we believe it is crucial, in light of the lengthy delays in introducing the current legislation, that our facility receive redress for the significant deficits we have incurred in providing care to those seniors who most need it. We have appreciated the strong indication of support from all the members of the Hamilton caucus of the NDP, as well as the strong indications of support from local members of both the Conservative and Liberal caucuses, in encouraging government to correct this serious inequity.

While we have need for immediate and retroactive redress, we believe the passage of Bill 101 will be a significant step towards equalizing funding to all seniors in long-term care facilities across the province of Ontario. We believe it is crucial for seniors in facilities to have the opportunity to start with this level playing field.

We would like to spend the next few minutes laying out some concerns we have with the legislation in its current form and provide some suggestions in terms of how the legislation can be improved. The major areas we would like to cover are: (1) governance and quality care; (2) seniors' right to choice; and (3) adequate and equitable funding to meet government-prescribed standards.

The first area of issue is governance and quality care. The board of trustees of St Joseph's Villa strongly concurs with those who have drafted Bill 101 in their efforts to ensure that high-quality service to seniors is the top priority. The Sisters of St Joseph of Hamilton, as owners of our facility, insist that a high quality of service be provided to all our residents, with a special emphasis being placed on the needs of the poor and the marginalized in our society. With this in mind, both our sisters and board have taken their governance responsibilities and their accountabilities to the local community very seriously.

I am certain that Mr Beer will recall, from his time as Minister of Community and Social Services, having received over 250 letters requesting his support to maintain the high quality of care which St Joseph's Villa provided at that time and continues to this day to provide. Those letters came primarily from the seniors being served by the villa and from their family members. In addition, all of the provincial, municipal, regional and federal elected officials in our catchment area have communicated their support for St Joseph's Villa to Mr Beer, to his two predecessors as Minister of Community and Social Services and to each of his successors in office.

During the period since 1985, to our knowledge, no minister responsible for the provision of long-term care has received one complaint, either verbally or in writing, relating to the quality of care provided to seniors or the services provided in support of families by our facility.

As a charitable home for the aged, we do not believe we are unique in terms of the level of community support and appreciation for the quality of care we provide. We also believe this has not happened merely by accident, but our positive reputation within the community has been earned by our board's responsiveness to the needs and concerns of our local community.

We are extremely concerned that the emphasis placed on inspections, sanctions and standards in the new legislation will simply be the addition of a new level of bureaucracy that duplicates a function which is currently being well done, not only by our board of trustees but by similar boards in homes for the aged across the province of Ontario. We would encourage your committee to take a further look at the strengths in the current system and build on those strengths rather than creating an unnecessary additional cost to the taxpayers of Ontario.

Our second area of focus is seniors' right to choice. It is crucial in terms of access to long-term care facilities that seniors continue to have the right and privilege to select what for many of them will be their final place of residence. We are concerned that Bill 101 in its current state reduces consumer choice and reduces the control that seniors have to make decisions that significantly impact on an important part of their lives.

In Bill 101, consumer choice is reduced when no right of appeal is guaranteed to the senior; when the right to reside in a home that can provide services that are religiously sensitive to their needs is not maintained; when the right to reside with a spouse is taken away because that spouse cannot meet rigid eligibility criteria; when a senior has to wait until the decision to access facility placement is forced upon them, rather than having the opportunity to preplan for this important move, and when seniors and their families are forced to try all other community alternatives when their stated preference is facility placement.

1540

We support a major role for placement coordination services and placement coordinators in assessing the needs of seniors. We have had an extremely successful relationship and partnership with the Hamilton-Wentworth Placement Coordination Service and look forward to the benefits which can be provided to seniors by facilities and placement services working in a cooperative manner. We, however, do not believe that cooperation can be legislated.

The role of the placement coordinator needs to take into consideration the desires of seniors, the needs of seniors and the ability and capacity of facilities to respond to both those needs and desires.

Finally, we are concerned about adequate and equitable funding to meet government-prescribed standards. We commend the province's initiative to ensure that standards are in place for the consistent provision of care to residents in all facilities across the province. In this area, we would simply request that the province ensure that resources are adequate to meet the care needs of seniors who access facilities that are funded by the government.

Bill 101 appears to take a major step to correct some inequities which go back over 20 years. While we would prefer perfect legislation, we find that the redistribution of available resources as identified in Bill 101 takes a major step in the right direction. We would ask the committee to push one step farther in this right direction and ensure that the resources are not only equitably divided, but that in addition they are adequately provided.

In conclusion, the redirection, the reform, the updating, the restructuring and the reconfiguration of long-term care in the province of Ontario have been discussed, have been consulted upon, have been responded to, have been put aside and have been laid over long enough.

The taxpayers in the province of Ontario have elected you to represent their interests. They have elected you to be decision-makers on their behalf. I would encourage you to take that responsibility seriously on behalf of the seniors in the province of Ontario. The time for action is now. I would urge your committee to act promptly and to put the new and appropriate legislation in place.

Thank you for your kind attention. We'd be glad to answer any questions you might have.

The Chair: Thank you very much. It's always interesting to be reminded of one's actions or, perhaps more appropriately, one's inactions. But we're glad that you're here and that we all have another shot at it. We'll begin the questioning with Ms Sullivan.

Mrs Sullivan: Thank you. As a matter of fact, I think I've written letters to Mr Beer, to Mr Sweeney before him, to Ms Akande, to Ms Boyd and to just about everybody else about St Joseph's Villa.

There are two points you've raised here that have not been raised before, because many of the other points you have brought to us have had some discussion. One of them is the question of preplanning for facility placement in times of strong physical need. We have just gone through the process of the Substitute Decisions Act and the Consent to Treatment Act. A major part of the thrust of that legislation is that one should be able to participate in advance in making one's decisions about what would happen to one later on, even if someone else had to carry that out.

I wonder what portion of your residents would have been in a preplanning situation, where they have looked at your facility and clearly it meets their religious needs, but they must have determined on their own or with their families that it would meet health care needs as well. Mrs Mahaffy: I would say that by and large, about 70% to 80% of the seniors who come into the villa have gone through some kind of preplanning. Certainly, we get a number of emergency and quick placements within the facility, but many of them have lived in the community for most of their lives and have had placement in the villa, whether it's for religious reasons or social reasons or specific to a special type of care that we provide, as a desire through the later years of their life and have gone to the placement coordination service well before they were ready for placement to ensure that they were on our waiting list when the need arose.

Mrs Sullivan: That was my next question, how did that evolve through the use of the placement coordination system? That was also done in advance?

Mrs Mahaffy: Yes, we have many residents who've been on our waiting lists for two and three years who are not necessarily ready when we contact them to come in at that time, but their name then comes up again on the list.

Mrs Sullivan: To the parliamentary assistant, is that preplanning contemplated as part of the role of the placement coordinator?

Mr Wessenger: Perhaps I'd better ask ministry staff, because my own indication would be no, it's not really part of it. But I'll ask staff just to confirm that's the case.

Mr Quirt: Any prospective resident can apply to be considered for eligibility for a long-term care facility at any point in time. They can also reapply within a prescribed period of time and they can reapply if their needs change. So if someone was to apply and was deemed eligible, they would then in that process indicate which facility they would want to be considered for and then they would go on that list and would have every right to say, "No, I'm not ready to go in yet; would you please leave my name on the list?" when they were called and their turn came up.

I think that's probably the process that would happen currently at St Joseph's Villa, that when someone's name came up, they would be asked if they are ready for admission. If they said, "No, not yet," then they would stay on the list, and that would be the same system under the new system.

Mrs Sullivan: You said they'd have to reapply. Now they don't have to. Now they stay on the list?

Mr Quirt: Once they were determined as eligible, they would go on the list and they would stay on the list until their name came up at a time when they were willing to move in.

Mrs Mahaffy: I guess our concern is that the requirements for determining eligibility are much stricter—

Mrs Sullivan: Exactly.

Mrs Mahaffy: —under the new legislation and that their name won't actually get to the list because they're not quite at that level of need yet, and then they go back to the bottom of the list.

Mr Jim Wilson: I'm not really personally familiar with the difficulties you've had at St Joseph's Villa, so perhaps in a nutshell you could tell me. Was it nursing care and the level of nursing care that you've been providing and you haven't been compensated rightly for it? Mrs Mahaffy: We have 179 extended care beds, and in a nursing review that was done in 1988 by the ministry, an extra 99 residents were identified as needing the extended care level of service. We're providing that amount of nursing care to those residents, but we're not being funded to do that.

Mr Jim Wilson: That's kind of what I thought your answer was, and it just seems to me strange to be so supportive of a bill that delists extended care as an insured service and replaces it with levels-of-care funding with no guarantee that you'll actually get appropriate amounts of dollars.

Mr Gerry Malcolmson: Right now we're anxious to get ahead, so we figure if we get the bill moving we'll get some reply. Right now we're getting no action. At least the bill will give us some direction. Presently we're in limbo and we don't have an answer for that problem, so we're hoping that the bill will cure part of that so that we can go forward.

Mrs Mahaffy: One of the things the bill does is to recognize that you have a mix of residents receiving different levels of care and doesn't pre-determine how many people you can provide an extended level of care to. One of the dangers, having identified that you have many levels of care and that you have to provide services up to that level, is to make sure that those levels of care are adequately funded to provide care at the level the residents require.

Mr Jim Wilson: I appreciate your frustration and I appreciate your position. Let me just say for the record you're in for a rude awakening, I think—again.

Ms Carter: I'd like to thank you for your very positive comments about the bill, and I think you've put your finger on the reason why this legislation is so urgent and why this particular piece of the whole picture of long-term care that we're dealing with had to come quickly. We have been criticized for bringing this in when other parts are not in place and people don't know what they're going to be, but obviously there was a problem with fairness of funding for institutions and that has to be dealt with quickly. I think that is the real picture there.

1550

The point that adequate funds must be available is one that has been raised and I think that's well taken. Retroactive redress: I don't speak for the ministry here, but I know that funding is very short and I would have thought that was something we would like to do but is unlikely.

I think it's great that you have a seniors' day centre as well as your actual residential facilities, and that you already have a respite care program, beds set aside for that, which seems to fit in very well with the kind of picture that we're looking at overall.

You did raise the question again that we've heard a lot as to whether the placement coordinator would be able to take the desires of the seniors themselves and the ability and capacity of the facilities to respond to those needs, whether those would be taken into account. Mr Wessenger did tell us this morning that there will be an amendment to the bill, so maybe I can just put that on the record once

more to state that the coordinator would take the preferences of the client into account, such things as ethnicity and so on; and also that facilities must have the staff and the equipment necessary to look after that person before that person would be assigned to them.

So I hope that does at least solve some of the problems that you have with the bill. I don't know whether you want to comment on that.

Mrs Mahaffy: Yes. I think certainly facilities have to be able to handle who comes to them. I think facilities have, by and large, been very flexible about doing their best to handle the residents that come to them. I think it's very important that we recognize that seniors need to have the right to choose and that we need not take that almost final right away from them, so that their final years are lived with dignity in the kind of environment that they would choose. They have chosen their environments up until this stage of their life, and I think, within our capacity to provide service, we ought to recognize that need on their behalf.

Ms Carter: I think that always has been the intention but it wasn't explicit in the bill. That has obviously been a great omission which is going to be rectified.

The Chair: Thank you very much for coming before the committee. I hope that, should you ever have to come to another committee, all of these concerns that have been expressed will by then have been met.

Mrs Mahaffy: And we won't mention our history again.

The Chair: History is always with us, but we are appreciative of your coming before us. Thank you very much again.

Mrs Mahaffy: Thank you very much.

REGIONAL MUNICIPALITY OF YORK

The Chair: I now call upon the representatives from the regional municipality of York, the community services department. The Chair would remind members that we've been privileged this week to have several representations from York region and delighted again to see those who are with us. Peter, if I could ask you to introduce yourself and the delegation and then please go forward with your presentation.

Mr Peter Crichton: Thank you, Mr Chairman. My name is Peter Crichton. I'm the commissioner of community services, which includes the responsibility for the seniors' programs within the regional municipality of York. I have with me today Shawn Turner, who is the administrator of our homes for the aged program and very directly involved in the impact of this particular bill.

The Chair: Welcome. Please go ahead.

Mr Crichton: I'm pleased to have the opportunity to make this presentation and address the standing committee on social development regarding Bill 101.

The region of York is supportive of many of the province's overall objectives for reforming the long-term care system, including the stated goals of the Long Term Care Statute Law Amendment Act. The region has identified a number of areas of concern regarding the proposed

amendments and wishes to present these to the committee and requests that certain assurances be provided by the province and that consideration be given to constructive recommendations made by the region to address these issues.

First, admission criteria: The revised admission criteria proposed under the new legislation will require the delivery of a wide range of medical procedures and treatments that are currently excluded and/or restricted under the Homes for the Aged and Rest Homes Act. This will result in higher care costs that over time will necessitate an adjustment in staffing complements requiring more skilled registered nursing and rehabilitation staff to provide this more complex care.

The region of York is therefore requesting a commitment from the government that it will provide adequate funding for: staff training and skills upgrading, heavier and more complex levels of care and staffing costs associated with the necessary realignment and intensification in staffing complements.

The second area of concern that we would like to bring to your attention is the funding system itself. The stated goal of this amendment to the legislation is to create a fairer funding scheme for all long-term care facilities. Based on our present understanding of the proposed funding formula, this goal will not be achieved, as it does not adequately recognize or account for legitimate variances in operating costs such as those associated with salary and benefit cost differentials among homes for the aged; unionized versus non-unionized environments; regional cost differences; pay equity; facility size, age and efficiency; increased laundry and dietary costs related to heavier care residents and economies of scale variables.

Accordingly, the region of York is seeking assurances from the government that the per diem compensation provided to facilities will recognize and fund these operating cost differentials. In addition, the region of York is seeking assurances that the per diem ranges for nursing and personal care will be established on the basis of the residents' actual care requirements and not on an artificial ceiling that is based on a predetermined, fixed global budget.

Failure to acknowledge these concerns and modify the funding system will penalize employers that have fully implemented pay equity plans, will penalize employers that are unionized and have higher wage and benefit costs and indirectly it will also penalize residents with heavy and complex care requirements.

The third area of concern is that of placement coordination. The region of York is supportive of the concept and potential benefits to the client of a centralized access system and placement coordinator for long-term care services. The region is, however, requesting that the government clarify the accountability of the placement coordinator and is recommending that a structure be established and implemented that will provide for a strong level of accountability to both the citizenry and long-term care providers in the local community.

The region of York is also requesting assurances from the government that the regulations governing the placement coordinator and admissions to long-term care facilities will include provisions for consideration of existing facility staffing levels when recommending placement, ability of the facility to appropriately care for the client, the right of facilities to appeal consumer eligibility and a formal facility appeal process.

The fourth area of concern that we'd like to bring to your attention is the area dealing with the resident copayment policy. Bill 101 proposes to amend the accommodation payment policy. Under the new policy, residents will be asked to contribute to their accommodation costs only. The amount that has been proposed is \$38 a day. The province has indicated that this will result in an additional \$150 million of new resident revenue, which is to facilitate funding of the reformed long-term care system.

The region of York has conducted an analysis of the actual amount of increased revenue that it would receive based on this revised resident copayment scheme. These calculations were based on the actual income levels and ability of the existing residents to pay the increased accommodation fee. This review indicated that the region's actual average resident copayment would in reality only be increased to an average of \$29 per day as opposed to \$38 per day. This represents a shortfall in potential revenue to the region of approximately \$3,000 per resident, or \$600,000 on an annual basis, not an insignificant amount. Of course, if one multiplies that over all homes, then you have quite a significant shortfall in anticipated revenues, something I don't think we want to underemphasize today. Accordingly, the region is requesting that the province recognize this differential in revenue and make a commitment that it will fund or provide the means to manage the shortfall.

1600

The fifth and final area of concern is that of systems planning and management. Although not directly part of Bill 101, the announcements from the minister indicated that district health councils will be asked to restructure their planning capabilities and assure the lead role in planning long-term care in their respective communities.

The region of York is concerned that this realignment does not provide for substantive and direct accountability to the local community, since district health council members are appointed by the province and not elected by the local citizenry. The region of York is therefore requesting that the government reconsider its proposed position regarding planning and management for the long-term care system.

The region of York is recommending that accountability of this function be strengthened and enhanced at the local level by establishing a requirement that this planning activity be coordinated through, and that plans be approved by, the regional municipal councils.

In all areas of human services planning, the region believes municipalities should be given the responsibility for designing the local system and managing that system within provincial policies and priorities.

In closing, the region of York is grateful for this opportunity to comment on the legislation at this stage and to participate in the development of Ontario's long-term care system. The regional municipality of York is offering its continued support and welcomes the opportunity of providing further

comment and assistance to the province as it proceeds with the reform initiatives. Thank you very much.

The Chair: Thank you very much for your presentation, and I note for Hansard the position paper from the community services and health committee that you have also left with us. We'll move right to questions.

Mr Jackson: Peter, thank you for your presentation. I'm on page 8 of your presentation and your concern about the separateness or the separation from regional municipal councils in this process. I guess this is the second time in a month that I've heard from York region about this process. I understand that with the review of day care planning and implementation, they've bypassed your council and your committee and gone directly to a community-based committee. I am, quite frankly, shocked and appalled, but I guess this is becoming a trend in York region and this government. That actually is going on now. They've bypassed your council. It's the only council that I'm aware of in Ontario where the government's done this.

Mr Crichton: Through you, Mr Chairman, in the region of York our council is concerned about the seeming proliferation of special-purpose bodies, not to the complete exclusion of the municipal process but certainly where the municipality is not adequately represented. It's the feeling of our regional council that we do have a duly elected process at the local level where there is direct accountability. They are on record as wanting to take a much more proactive role in what they call system architecture and system management at the local level, recognizing the responsibility of the province to set overall policy and priorities.

Mr Jackson: Yesterday we had with us the chair for the Niagara region. I posed several questions to him vis-à-vis the process of disentanglement and the fact that, in a peripheral way, the social services' partial contribution at the municipal level is part of the disentanglement process; it should be part of the disentanglement process. Yet here we have legislation which clearly speaks to your contribution at the municipal level, your lack of say and control in that process, and yet disentanglement discussions seem to be going on somewhere in this province separate and distinct from the activities of this community and the direct involvement of municipalities.

You've begged the question of how you're going to deal with a shortfall when the province sets all the rules, sets all the guidelines, sets all the rates and you're left with your rhetorical question, "How are we going to deal with the shortfall?" when we all know that you're just going to have to turn to council and say, "This is the shortfall." Is that a fair—let me just say that that was a concern that the regional chairman for Niagara shared with us as well. Although you don't hold an elected position, you are very much here on behalf of your council.

Mr Crichton: We are here, as you can see from our council minute, at the direction of council and are reflecting council's position on this matter. Council is concerned that in many of these disentangling exercises the municipality will be left with the fiscal responsibility but without an appropriate say in the, as I said, system architecture and design. The region of York has its own concerns around

the first phase of disentanglement, which we have made available to the process that's going on now, the shortfall between the tradeoff of roads and welfare, and there is quite a significant shortfall in the region of York. But we are also concerned about what we don't know about yet, which is the other stages of disentanglement, where we begin to include the other parts of the human services piece: namely, long-term care, child care, certain health concerns and so on and so forth. We don't know the whole piece yet and we remain concerned.

Mr Jackson: I appreciate that. Perhaps Mr Wessenger might respond directly to the question. What is it that we're going to be telling the region about its shortfall of about \$600,000? Are we to reduce service, are we to reduce beds or are we to just come up with the money locally? Perhaps in his time he might be able to respond. I think it's one of the most important questions raised in the brief.

Mr Wessenger: I think I'm going to have staff comment on their figures on page 7. I'll ask staff to indicate whether that is accurate.

Mr Quirt: The province has made a commitment to homes for the aged, primarily municipal homes for the aged, but also a small number of charitables that we anticipate are now spending more in the operation of their facilities than they'll be entitled to under the new funding formula. The commitment is that our level of support, the support provided by residents and the province together, will not be reduced and those facilities will be, in effect, red-circled. In other words, the existing level of support they receive will be maintained and there will not be a resulting increase in the contribution that municipalities now make to the operation of homes for the aged, which on average is, if memory serves me correctly, about 15%.

With respect to the shortfall in resident revenue, it is the intention of the province to make up 100% of the difference between what residents are able to pay based on their income and the \$38 fee that will be asked of residents who are not in receipt of the guaranteed income supplement.

The Chair: Comment or further question on that?

Mr Crichton: At this point we were not aware of that commitment on the part of the province. We welcome it. Right now our share is approximately 18% rather than 15%.

This is also tied in of course with the other comments we made. It's not only the \$38 or the \$29 copayment, but the increased costs due to the complexity of care that will be demanded. We are already having difficulty keeping up with the level of care required by our existing residents without these added treatments and programs, particularly in municipal homes for the aged where we are getting, I believe, a higher proportion of special needs residents. I mean, beyond the sort of traditional residential care and your basic extended care, we're getting people with very heavy care needs.

1610

The Chair: Mrs Sullivan, did you want to ask something on this specifically?

Mrs Sullivan: Yes, I wanted a clarification. With respect to the resident fees, we've had a very clear statement

that the province will make up 100% of the difference. However, the director has indicated that, while municipal homes won't receive less when the transfers are made, he did not indicate that those funds will be frozen until there's an equivalency between the municipal and charitable homes costs and nursing home costs. I think that has to be very much on the table and very much a concern of municipal councillors.

Mr Larry O'Connor (Durham-York): We certainly do hear from York region, in this committee, some different concerns, and seeing such a good representation from York region, I'm delighted to see that the care and the human services element in York region is a concern not only to council but to district health council, which came before us, and the placement coordination service that came before us as well.

Again on page 8 of your brief you talked about the district health council and some concern about accountability. I know we have regional council representation on the district health council; just this week they're taking a look at establishing the subcommittee that will take a look at this concern of long-term care and the planning aspect of it. Did you know about the meeting Monday night put on by the district health council and was somebody from council there to represent the concerns of York region and your department?

Mr Crichton: We do have representation on the district health council and my understanding is that representation was there from the region. I think the issue here—the region of York, as I understand it, has been very supportive of the formation of the district health council in the region. The council has been very supportive but, at the same time, I think the council is looking sort of beyond that. At the moment, I think for those of you from the region of York-Mr Chairman, Mr O'Connor-you recognize that we are embarked on a process now of developing a regional official plan and, I believe, at the same time the regional council is examining its role in a number of matters and is beginning to express an opinion that its role goes beyond water, sewer and roads and that it has a much more direct role—also a bigger role to play—in the whole human services piece. I think they're beginning to express that, to formulate that, so I think you will see them testing the water, as we move through this piece over the next year or two.

As we expect to grow—our population projections look at almost a doubling of the population over the next 30 years—we have to start paying attention to some of the bigger issues you need to attend to in community building, and I think that's what we're doing. It's not only an increase in population; we're building a different kind of community, a more livable and sustainable community.

Mr O'Connor: I know that going through that process—it certainly is an exciting process we're going through right now in trying to develop that official plan and I applaud the region for trying to take a look at the human elements as well. I hope they don't overlook some of the other community aspects, that we do have support in the community; for example, the community services

council which offers some areas of expertise that I would think the region would want to take a look at in concern and bring them along with it and the district health council, of course. I'm sure York wouldn't overlook that. I know that the members who represent York in the Legislature have all been quite supportive of the district health council and I'm sure we're all looking quite forward to seeing the regional plan actually come into being at some point in the relative near future.

Mr Crichton: The members of council do not want to exclude the district health council or any other body within the community, but rather bring those bodies into the democratically elected process that has been set up within the region of York.

The Chair: If I might put on my other hat briefly, I'd like to follow up actually on some of the questions in terms of the regional planning function and, really, in the sense of strategic planning around long-term care and the district health counfeil community services council. I think you are quite right in underlining, in the last few years in particular, a greater interest expressed by council to be more involved in a number of those decisions in that planning.

I realize that because the district health council is itself quite a new entity, and that you're working with them and looking at a number of issues, and I realize this is partly speculation, but in terms of the role of regional council and its relationship to what are two provincially appointed bodies, ie, the district health council and the community services council, as you look at a framework or a way of putting that together, how do you see that operating, that in the case of I suppose broadly speaking social planning and health planning that those bodies would present those plans before regional council, that this would become part of the process, whether it was long-term care or child care or what have you? Or would it be regional council and through its committee system that would have the primary function, initially, in developing those plans? Have you thought that one through at all?

Mr Crichton: In discussions to date with members of committee and members of council, it certainly hasn't been to the exclusion of any of these other bodies or any of these other processes that exist within the community, and the questions that are being asked today are, how do we link ourselves with those other processes to ensure that it's not just committee or it's not just staff coming up with planning, but how do we incorporate processes that exist or the works of bodies that exist in the community—exist today or should exist—how do we put them together in a meaningful kind of process whereby decisions that affect people at the local level can be made appropriately by council?

I don't hear council saying, "We've been elected to make the decisions, so therefore leave us alone for three years," but rather, "How do we begin to link up with the community processes that exist and build ones that are not there but should be there so that we can build a better community and a more appropriate one, a more relevant one?"

The Chair: One other question that maybe, Shawn, you might be interested in sharing your thoughts with us on this. The placement coordination function, in terms of

the way that works currently in the region, do you see this as a model that in effect could be taken over and used, or are there some particular things that you think need to be altered in the way that system currently works?

Mr O'Connor: I might just add to that, they have pointed to some concerns around existing facility staff levels and concerns around placement, and maybe they've had some problems and they might want to point that out, if that's the case.

Mr Shawn Turner: In fact, at present, we haven't had those problems because the existing legislation allows us to review referrals and make a determination at the home level, whether or not we have the appropriate capacity to care for the client being referred to us.

Our concern would be with the new placement coordination service, that at that time, based on our understanding of the present funding or the proposed funding, we would not have a capacity to retain the same degree of social work that we presently have in our system, and that we would then be relying more heavily on the placement coordination service to do a more full and thorough assessment.

The type of assessment we currently receive from the placement coordination services I think we would deem to be inadequate, and certainly we do find the necessity to conduct a more complete assessment with our own staff. We would hope that in the reformed placement coordination system, they would have adequate staffing to perform thorough, complete assessments of the clients being referred to the facilities.

The Chair: I have to put my other hat back on now and move us along. Larry and I would be happy to stay here and just talk about York region, but that wouldn't be fair to the other parts of the province. I want to thank you both very much for coming this afternoon and for your presentation and recommendations.

Mr Crichton: Thank you very much, Mr Chairman and members of the committee.

1620

SERVICE EMPLOYEES INTERNATIONAL UNION

The Chair: I then call upon on our next presenter, the representatives of the Service Employees International Union, if they would be good enough to come forward. Welcome to the committee. Once you're settled, would you introduce yourselves for Hansard. For the committee members, we have a copy of your submission in front of us.

Ms Judi Christou: My name is Judi Christou. I'm here representing the international vice-president of Service Employees International Union. With me are Marcelle Goldenberg, director of research, and Lin Whittaker, nursing home coordinator for Local 220 in the London area. We welcome this opportunity to present our views to the standing committee on social development concerning Bill 101.

This union represents approximately 45,000 workers across the province. Of these, 11,000 are employed in nursing homes, municipal and charitable homes for the aged. We also represent over 27,000 members employed in 93 hospitals. Some 85% of our members are women and many are visible minorities, particularly in the urban areas.

It goes without saying then that we are intensely and primarily concerned about the proposed long-term care reform and its impact on our members. We made a submission last year to the Minister of Health regarding the public consultation paper in which we stated that our members, as workers, have a substantial amount to lose and very little to gain from the proposed reforms.

This union is also concerned about the long-term care reform because we represent 45,000 consumers of health care, many of whom are in the unique position of participating on the front lines of the system and believe they have something significant to contribute to reform.

We feel that we are being asked to comment on Bill 101 in isolation, without knowing the policy directions resulting from the long-term care consultation and the details of the implementation framework. Indeed, we would be much more comfortable critiquing the bill if we knew how the government sees chronic care and acute care hospitals fitting into the picture.

We are also waiting for the chronic care role study that's supposed to be issued early this year. On the one hand, we are assured that workers displaced from the institutional care setting will be absorbed by community care while, on the other hand, workers who are currently being laid off from the hospitals have nowhere to go. For these reasons, we feel the need to reiterate some of the scepticism expressed in our submission on the original paper.

The shift in emphasis from institutional care to community care implies that there is something inherently wrong with institutional care and that community care is somehow superior. We submit that there is a need for both types of care as long as it is quality care, and that the government should remain flexible as to what that balance should be. If it is felt that institutional care is somehow failing the client, then institute reforms by all means, but we don't agree that this sector should be downsized or any thought of future expansion dismissed. We say this for a number of reasons.

The 1990 auditor's report documented long waiting lists and significant delays in the placement of patients in nursing homes and homes for the aged, presumably because there was a shortage of beds.

Then there's the question of the demographics, which I'm sure you are very familiar with by now. We are just concerned that if there are no institutional care beds for people who are cognitively impaired, will community care be able to provide the 24-hour supervision for each and every one of them?

Also, community care puts enormous emphasis on care givers, and most of the care givers are women. Today, for the most part women are in the workforce and/or looking after children. To expect them now to shoulder the burden of caring for infirm relatives is unjustifiable. Therefore, the practicality of this solutions as it is presented eludes us, unless of course the government assumes that community care will be a lot cheaper.

We stated earlier in our submission that we represent the front-line workers in health care, workers who are predominantly women and visible minorities. Just when collective bargaining, pay equity, labour law reform and the potential of employment equity are acting in concert to eliminate long-standing disparities, the government decides to transfer this work to the community sector that has traditionally been lower-paid and unorganized.

Currently this union represents four units of home-makers, or community care workers if you prefer. Two of those units are currently on strike and have been on strike for about a week and a half. They are actually paid more like \$4 to \$5 less than institutional care workers and they get little or no benefits.

The consultation paper stressed the importance of job security and decent wages for our members, but after decades of being scapegoats for government and employers, we remain sceptical.

Within that frame of reference, we will make a few remarks on Bill 101

Residents, workers and taxpayers have for years called for greater accountability in the health care sector. This can only be accomplished if the system is opened up to allow for the participation and scrutiny of stakeholders. This is true too of the hospital sector, where we're seeing a little bit of progress, such as the implementation of hospital operating guidelines and staff planning committees which provide for the participation of unions and other groups. We believe Bill 101 should also be reflective of these democratic principles, specifically with regard to the service agreement, quality assurance, plan of care and inspections.

We do not know what the form and content of the service agreements will be as this is left up to regulation. However, we see certain similarities between this and the social contract proposed as part of the Public Hospitals Act review. We firmly believe that, like the social contract, the service agreement should be negotiated with the participants of the system, mainly the community, the residents and the workers. Similarly, the quality assurance plan should involve everyone at the workplace on a day-to-day basis and not simply be a reactive approach to incidents or individual performance.

Regarding the plan of care, the bill provides that the requirements of each resident be assessed on an ongoing basis; however, it does not say who is to do the assessing. We would assume that at least a doctor would assume that resident and, hopefully, the registered nurse assigned to the resident. Bill 101 makes no mention of the residents themselves or their families, but we believe they'd be an integral part of the plan of care. Similarly, staff such as the registered nursing assistant, health care aide, activity aide, who are primarily our members, could also provide valuable insight into a patient's needs as they are the ones who work with the resident on a day-to-day basis and provide the hands-on nursing care.

The inspection system has been a constant source of criticism in the past. Inspections, if they were held at all, were often scheduled far in advance, enabling a home to bring its requirements up to standard on a temporary basis. For this reason, we believe that inspections should not be scheduled in advance and that inspectors should speak to the workers in the facility and vice versa. However, this will only be effective if strong language appears in the acts protecting workers from reprisals of any kind from the

employer or any other bodies. It is simply common sense to allow workers in the residence to report on conditions in the home without fear of reprisal.

Bill 101 requires the facility to post copies of those financial statements, reports and returns filed with the minister in accordance with the regulations. Therefore, we are unaware of the scope of the data to be made available to us. Regardless, we are here to ask for full and unrestricted financial disclosure, particularly with regard to the forprofit facilities.

Unions have, to be sure, a specific need for this kind of data. For the most part, every contract in the health care sector proceeds to interest arbitration. Almost without fail, the management will plead poverty or inability to pay year after year. Some arbitrators have rejected this argument, as jurisprudence would suggest they do, but others do not.

Recently we faced such an argument and the employer tabled a form 7 in support, which reveals very little about the financial state of the home. In order to respond to this argument, we requested financial data, some of which are documented on page 10 of the brief. This is just an indication of the kind of data that are available and also how money can be manipulated and hidden from view.

This union and many other groups have pursued full disclosure before the Public Hospitals Act review and we are hopeful that the review will result in mandatory disclosure provisions. Recently we received an arbitration award which required the hospitals to provide staff planning committees with pertinent financial and staffing information. This is only a beginning, but we believe the public institutions can no longer conduct their business in secret. If you want accountability, you have to have disclosure.

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We have a couple of comments about funding. In reading the original discussion paper, we assume that the residents will not have to pay for nursing and personal care services. The bill is not as clear, however, and states that charges for various classes of services, goods and programs shall not be in excess of amounts determined by regulation. We hope the original intent, as stated in the paper, will be reflected in the bill or the regulations and that no residents will have to pay for their own care.

As a union, we take the argument one step further. The government must fund an appropriate level of care without expecting health care workers to subsidize that level of care by means of substandard wages and benefits. In our view, they have done so for many years and are continually expected to do so. In spite of the goodwill statements in the consultation paper regarding job security and working conditions for our members, we see no indication that the present situation is going to change. We think the homemakers' strikes are symptomatic of this.

The bill gives no indication of what criteria are going to determine who will be admitted to these facilities and who will not. This is going to be dealt with in the regulations. The bill also gives no indication, as would be expected, as to what happens to those people who do not meet the criteria. Presumably they would need community care, and we are hopeful it will be available for them.

In conclusion then, I think we're all in agreement that reform is badly needed in the health care system, but we maintain that it must be done on the basis of the whole system and not on a piece-by-piece basis. It must also be done on a fair and equitable basis. This union will do everything necessary to see that it is not done at the expense of our members.

There are still so many questions we have about community care that have yet to be answered: Where is it? Who is going to do it? What are they going to be paid? Will they be organized? What about the homeless? What about the cognitively impaired? There are still so many questions about this bill primarily because the essential elements are left up to the regulations, which we have yet to see

Thank you for listening to our presentation. If you have any questions, we'd be happy to try to answer them.

The Chair: Thank you very much. I've just recognized that there is more in your presentation than you read. I was concerned at the beginning that we wouldn't perhaps get it all in. I just want to note that there are other elements. We appreciate that and will have an opportunity to look at them, but it also means we have time for questions. We'll begin with Mr Owens.

Mr Owens: I just want to begin by thanking you for your presentation. In my former life I was the president of CUPE Local 2001, Toronto General Hospital. I have some intimate knowledge about what it's like to bargain a collective agreement with a health care provider. While on the one hand they beat their breast and talk about compassion and excellence, on the other hand they try and push people into the corners and do everything they can to save pennies.

You make some really interesting comments. I want to go first to page 13. You talk about admissions. What has been your experience around admissions in terms of the patient mix or resident mix you are currently dealing with? Have you been exposed to inappropriate admissions, perhaps a person who, for instance, may be developmentally handicapped but also has psychiatric difficulties, or have you had difficulties with not being told that a resident or patient is potentially aggressive?

Ms Lin Whittaker: I coordinate the nursing homes in London, so we're talking about 20-odd nursing homes. Over the last few years we've found that the type of resident patient certainly has changed in terms of more care being given. One of the problems we have, and continue to have, is that our members are not informed of any difficult, for lack of a better word, residents, if there are violence and psychiatric problems. We try and ask for information so we can know how to deal with them, if we're given any guidelines, and that has not been forthcoming.

This year our local union, as our sister local did, has language in collective bargaining to try and get at that, to have disclosure on residents so we can assist them, help ourselves and not put ourselves in a situation that could be potentially dangerous to health and safety. To date, we've had no support for that. It's sort of that, with all due respect, it's none of our business.

Mr Owens: Interesting. In terms of inspections, accreditation and quality assurance, as worker representatives—and presumably at some point you worked on the shop floor yourselves; I certainly know people who currently are employed there—what's your experience around quality assurance? Is it real? How is it done?

Ms Whittaker: Are we talking about the inspections?

Mr Owens: Inspections? Absolutely.

Ms Whittaker: They have no value at all. It's known. We always know when there's going to be a pending inspection because all of a sudden the food comes out, the towels are replaced, the toilet paper's there, the Attends, the diapers. So we know. As soon as the inspection's over, then those things disappear. It's frustrating. I've seen our members bring food to residents because they view these residents as their family. It's not a relationship where there's no feeling. We think the present system is a farce. It gives lipservice to what it's supposed to do.

Mr Owens: We've heard presentations from residences, both secular and non-secular, saying that our language with respect to inspections is coercive, draconian, that it's going to promote confrontation. Have you had a chance to review the language that we're proposing under Bill 101? Do you see it as a means to begin to address the issues? If it does, I'd certainly like to hear about that. If it doesn't, where would you like to see the changes made?

Ms Christou: I don't think there's strong language in the act protecting the workers from reprisals from the employer. That's got to be there.

Mr Owens: The whistle-blowing protection.

Ms Christou: Yes, exactly.

Mr Owens: Would you like to expand a little bit on that?

Ms Whittaker: Yes. I don't know how personal you want us to get. In the last few weeks, we have had information pickets; our members are not able to strike. We're concerned that the Ontario Nursing Home Association has been telling its member organizations that there's a 0% increase. We've seen a lot of cutbacks.

Mr Owens: Fearmongering?

Ms Whittaker: Yes. We understand what they're doing. They're trying to justify the layoffs. We've got to the point where our understanding is that the nursing homes are still funded on the current level and care has been cut back. We've seen reduction in care staff, shifts being changed. Health care workers have been reduced, and we've been picketing. We've sent copies of our letter to the nursing home inspection branch; we've sent copies down to the ministry.

It's not unusual, when we have our regular unionmanagement meetings, for that to be on the agenda, that somehow we would not be viewed as being chastised for having the nerve to contact the nursing home inspection branch to talk about the reduced care. But that's a separate issue. We start off the grievance procedure if people are suspended or disciplined for that, and that happens; that's real. Mr Owens: So workers end up suffering in terms of doing what they view as their duty to their patients or their residents?

Ms Whittaker: Yes. I think somehow there's a power imbalance, that somehow that role is not expected of us.

Mr Owens: You're simply there to be clones.

Ms Whittaker: We give the front-line care, but we shouldn't care about the residents. We are their families.

Mr Owens: We know that's not true. You're there to care.

Mrs Sullivan: Just before I ask my question, may I remind members of the committee and those in the audience that this government had intended to bring in whistle-blowing legislation, as I recall, and so far it hasn't hit the floor of the Legislature.

However, I want to turn to the issue you raised on page 11 with respect to the arbitration award you received recently, requiring hospitals to provide staff planning committees with financial information. Is the information that you will now receive that which you have listed on page 10, or what did you ask for and what were you granted?

1640

Ms Marcelle Goldenberg: The arbitration award we received requires that the hospital, and specifically if it's making changes from a human resources point of view, table with the union all pertinent information and have full disclosure. We would then request from an individual hospital the information we think we would need to be able to make an assessment in that particular situation.

What you see on page 10 is our list of what we believe would be the disclosure required in an arbitration setting for a nursing home, to make an assessment whether or not it has a valid ability-to-pay argument. This was a partial list, and also in consultation with some accountants, to give us an indication of what we would need to know to get a complete financial picture, because in most situations, either in a bargaining session or an interest arbitration session, we would find that the information in Form 7 does not disclose all the information.

For example, many nursing homes will mortgage. It will be highly leveraged and therefore will have a lot of mortgage payments to make, at very high interest rates. That doesn't really give us a true indication of the viability of that particular home. It may be that they made a financial decision to mortgage the home at 90% instead of perhaps offering a mortgage or having a mortgage at 50% of the value of the home.

We would really like to know in terms of what information they have so that we can make an assessment. In some cases, when they do that, especially in a limited partnership, we find that they're able to make the financial picture look very poor but the actual picture is not as poor as it looks.

Mrs Sullivan: I want to go back to the issue with respect to the real estate. Are you aware that there are many banks in Ontario that are ready to foreclose on nursing home mortgages?

Ms Goldenberg: We know there are 14 nursing homes out of 227 in this province that are currently in receivership, and that is different than being in bankruptcy. We have looked on some occasions at the finances of those 14, since some of them are SEIU homes, and some of the information we have looked at seems to indicate that some of the management of those facilities have been involved in questionable financial practices that we think are quite separate from the operation of that particular home.

Mrs Sullivan: And who made that analysis?

Ms Goldenberg: From the information we have from either our accountants or union staff having the ability to look at some of the information.

Mrs Sullivan: When you are saying questionable financial practices, are you indicating that there is something that has been illegal occurring?

Ms Goldenberg: No, I'm saying that there are some practices that have been committed or practised by those particular homes which have nothing to do with the operation of the homes, decisions that those owners have made regarding their particular home.

For example, they may have made a decision to mortgage that facility at 90%. They may have made a decision to flip the home and have it sold four times in four years, each time increasing the real estate value of the home but not necessarily—and all of these are financial decisions that don't have anything to do with the day-to-day operations of the home. Do you see how we separate those two issues when they're out there to make a profit?

Mrs Sullivan: Yes, but on the other hand, the ministry funding is separate from those capital issues and therefore your operational funding, which pays the workers, is quite separate from those capital details.

Ms Goldenberg: No, not in the nursing homes. In the nursing homes you get the per diem. Each nursing home receives a per diem, and of the per diem it is to pay the workers, pay for the food costs and provide for all the operations. I don't believe that the capital funding is separate. There's a profit motive in the nursing homes, and obviously that is a problem.

Mrs Sullivan: How do you explain, then, that the summary of the for-profit nursing homes as well as the not-for-profit nursing homes from the Form 7s indicates that the for-profit nursing homes are losing approximately \$2 per bed per day and the not-for-profit nursing homes are losing approximately \$4 per bed per day? Both of the sectors are in deep trouble.

Ms Goldenberg: Both of the sectors need more funding; there is no question about that. What we're saying is that if you look closely at some of the for-profit homes, you will find that some of their practices contribute more to their financial picture than others.

The Chair: On that, I'm afraid I'm going to have to bring this to a close. I want to thank you for coming today and for your presentation and answering our questions.

ONTARIO ASSOCIATION OF DEVELOPMENTAL SERVICE WORKERS

The Chair: Could I next call upon the representative of the Ontario Association of Developmental Service Workers. Welcome to the committee. Would you be good enough to introduce yourself, and then please go ahead with your presentation.

Mr George Anand: Thank you, Mr Chair. My name is George Anand. I am the president of the Ontario Association of Developmental Service Workers. We welcome the opportunity afforded to a young and growing association like ours to present our viewpoints.

We feel this legislation is coming on the tails of three other legislations that we have just seen: substitute decision-making, consent to health and advocacy. As we look at those three legislations, one of the questions we have been asking is what kind of impact all those three legislations are going to have on the delivery of services and the impact those legislations are going to have on the direct service care workers while they are performing their jobs and responsibilities under Bill 101.

We like the principles behind Bill 101 that we understand are definitely to curb abuse, reduce duplication of service, look for better coordination and provide more empowerment to the consumers and the service providers, and we do appreciate the bill as it talks about taking into account the cultural sensitivities. But when looking at this bill, we also looked at the fact that this bill talks about providing empowerment to two groups: to the old-aged and to the physically disabled. One question we have asked is how those people who are developmentally disabled or those who have psychiatric disabilities, these particular two groups, are going to be affected under the provisions of Bill 101.

We are a growing association. At the time we started, we basically got together with the direct-care workers who have been working in the area of the developmentally handicapped and decided that we needed a professional association for the people who work as direct-care workers in the area of the developmentally handicapped. But since that time, we are in the process of opening our membership to the people who are working in the area of psychiatric disabilities and to those who are working with the old-age population. As we open our membership, we do realize that there may be more perceived differences rather than real ones in terms of the jobs, in terms of the skills, in terms of the training that's required by those individuals who are working in direct care in the field of developmental disabilities, psychiatric disabilities or old age.

1650

Considering that framework, we also looked at some of the questions that had been raised in the consultation paper. It talks about the issue of accountability. For example, on page 25 it definitely talks about what process could be used to handle complaints and concerns of people receiving health, personal care and support at home. Then on page 23 there's a reference that new provincial training guidelines will be developed for health care aides who work in long-term care facilities and for workers providing personal care and support to seniors and people with

disabilities in their homes. Then it talks about workers being trained to do a variety of tasks. Then it also talks about what kind of training or upgrading the workers should have.

Looking at all this, from our point of view we definitely feel that an association like ours should be given more authority to regulate itself. So with that kind of having a self-regulatory function within our association for direct-care workers, we feel that under certain provincial guidelines that are provided, those are some of the guestions that had been raised in the consultation paper on accountability, on the training aspects and how our members need to govern themselves under different pieces of legislation: consent, advocacy, substitute decision-making and the other legislation. We are already in the process of striking a committee so that our committee members could go and start passing information to our members on these different legislation: what kind of impact it's going to have on their functions, on their responsibilities, on their duties, So having that kind of authority to regulate ourselves, perhaps we can take care of some of the questions that are being raised around those issues of accountability and on training guidelines etc.

We looked at the Globe and Mail. They were talking about people who are psychiatrically disabled—on March 6 it says, "The Garbage Bag Evictions."

"Discharged psychiatric patients are in a terrible bind. They may be unhappy living in homes with poor care, but they are even more fearful of having no home at all."

Considering some of the other population groups that we may be going through, we definitely feel that the psychiatrically disabled and those who are developmentally disabled should be given the same opportunity as those given to the physically disabled. When the physically disabled have more empowerment, they can take the funds, they can see what particular service they want and what kind of services and in what manner the funds should be spent, so the same opportunity, the same empowerment, should be given to the other groups as well.

The Chair: Thank you very much for your presentation. Just before beginning the questions, could you just tell us when your association was founded and approximately how many members you have in the association, roughly?

Mr Anand: We started this association at the end of 1986. At the time we started, we circulated a petition among the institutions to see whether there was any interest to form an association for direct-care workers who are working with the developmentally handicapped. We got 400 signatures on the petition. As a result of that petition, we formed a steering committee to come up with the guidelines on the basis on which this association could be formed.

As we moved along, at this particular time, last year itself, we became an incorporated body. We are incorporated with the Ministry of Consumer and Commercial Relations. Our present membership is 125, but we have formed different chapters. Our resource, again, is the people who are working. We have a lot of items on our agenda, but in terms of our resources we are very, very

limited because we are a few people who, besides our own jobs, have been carrying on the burden of this association. But we are definitely in the process of looking for more resources, at tapping some other kinds of funding sources.

The Chair: Thank you. Ms O'Neill.

Mrs O'Neill: Could I just continue a little further along on the Chairman's questioning? Could you tell us a little bit about what kind of professions your association represents? You said the people you work with are the psychiatrically and developmentally handicapped. Could you tell us a little bit more about what kind of work you do with them and what kind of professions your association encompasses?

Mr Anand: The members, at the time we started, are providing the direct-care services to the developmentally handicapped. That is in terms of personal care and supports. So our members come from the institutions, from the community, those who are working in the group homes, plus we have members from the teaching institutions, from the community colleges, like the student members, and two of the instructors there in the community colleges are our board members.

So the way we started was in terms of direct-care workers who are providing personal supports and care to the developmentally handicapped, but as we moved along, we also felt that at this particular time there was no professional association that existed at this particular stage for health care workers who work directly either with the psychiatrically disabled or with the old-age population. Considering that, last time in our executive we decided to open our membership to the direct-care workers who are working with the other two population groups, with the psychiatrically disabled and with the old-aged as well. This is the decision that we have taken and this is the direction that we are moving towards.

1700

Ms Carter: The developmentally disabled and those with psychiatric disabilities, I guess, are not actually dealt with in Bill 101, but on the other hand they are closely connected issues and obviously are going to have to be dealt with at some point.

You referred to the articles in the Globe and Mail and, of course, Peterborough, where I come from, is part of that picture. Certainly in my own riding that link between the requirements of the groups you deal with and the other groups has become very plain. One of the things that is talked about in that article is the fact that a certain home which largely has elderly residents had a component of people who have been discharged from psychiatric institutions, and the owners of the home gave notice to those people that they had to leave by a certain date. Of course, this caused an uproar in the community and everybody's well aware that there is a gap in suitable accommodation for those people.

Also, we have a similar problem with the psychiatrically disabled who have a drop-in centre which is very valuable to them and they're in danger of losing that too. We even had a letter in the local paper very recently signed by, I think, three residents of the seniors' home that is

concerned in all this, saying that these people had been very disruptive, wandering around the hallways asking them for money, handouts and this kind of thing and they really felt they shouldn't be subjected to this kind of problem. I'm just wondering what, in the light of all this, you feel about the Lightman report which of course addresses the kind of lodging that a lot of these people find themselves in, and what you think some of the solutions might be.

Mr Anand: From our perspective we feel that the solution is definitely in terms of how to empower first of all the direct-care worker who will be the first contact person. who will be the first contact with the psychiatrically disabled. So if there's more training, if there's more skill, and if there's more knowledge, the direct-care worker who's coming into contact—and that direct-care worker also needs to abide by certain standards that we are in the process of setting up as an association. Then, of course, somewhere down the line we definitely would like to see ourselves as a regulated body too so we can monitor that our members are fulfilling or living up to those kinds of certain standards. So by empowering the direct-care worker, that definitely would go a long way in terms of providing a quality service to the individuals you have just referred to.

At this particular time we are seeing that the problems are a lack of uniformity, lack of consistency in terms of standards, and we don't feel there are any expectations on direct-care workers that they have to meet or that they have to abide by certain standards, so they have to be monitored in a certain way.

Ms Carter: You're really saying that standards of this kind would be an extra safeguard for the people living in these institutions, in addition to the right to appeal to an advocate and other safeguards; this is another approach. Thank you.

The Chair: Thank you. I regret again that time is pressing on, but I would like to thank you very much, Mr Anand, for coming in and making your presentation and also for providing us with information on your association.

ONTARIO MULTIFAITH COUNCIL ON SPIRITUAL AND RELIGIOUS CARE

The Chair: If I could then call upon the representatives from the Ontario Multifaith Council on Spiritual and Religious Care. I don't know if the clerk has done this by design, expecting we would need spiritual care at the end of the day, Reverend Pfrimmer.

Rev David Pfrimmer: I could also preach, probably for about 45 minutes, but I'll spare you that.

The Chair: We want to thank you very much for coming today. Also, I know that you have been with us a good part of the afternoon. We are running a bit late, but we really do appreciate your coming. We have a copy of your presentation in front of us. If you'd be good enough to introduce yourself and your colleagues for Hansard, then please go ahead.

Rev Mr Pfrimmer: My name is David Pfrimmer. I work with the Lutheran office on public policy. I chair the research and development committee. With me are the

chairperson of the Ontario Multifaith Council on Spiritual and Religious Care, the Reverend Karen Bach, who works with the Presbyterian Church in Canada, and the past chair, Imam Yakub Khan, who is with the Toronto and area region Islamic community.

We're also pleased that you're willing to hear our presentation after a long afternoon and day, I'm sure. We've circulated to you. I'll briefly share some remarks and then if you want to have some questions, we can do it that way.

I want to say that the members of the Ontario Multifaith Council on Spiritual and Religious Care applaud the government's willingness to reconsider and improve the care provided to seniors and disabled adults of our communities across the province. How we care for those who are in need is fundamentally a reflection of the values that shape and sustain our communities.

The major concern of OMCSRC, as it's affectionately referred to, is the uncertain commitment to meeting the religious and spiritual needs of seniors and disabled adults. OMCSRC believes that there needs to be a declared recognition of the importance of the integral provision of spiritual and religious care in any long-term care considerations, for three reasons. I'll briefly highlight those in my remarks: first, the effective strengthening and meeting of the needs of seniors and disabled adults; second, a fuller understanding of the nature of community; and third, government's recognition in law, charters and codes of the importance of religion in the lives of its citizens.

I will briefly elaborate on these three areas to support our call for inclusion of a commitment to provide spiritual and religious care to seniors and disabled adults.

First, it's been documented in various studies that among the elderly, particularly those 75 years and older, there's a strong connection between faith and wellbeing. While growth in spirituality is a lifelong task, the senior years of a person's life are often a reflective time in which he reviews the meaning of his life. This can be a time of tremendous doubts and uncertainty. It can be a time to wrestle with questions of life and death. It is a time of evaluation to deal with the unresolved issues and experiences of life. It is also a time to draw comfort, hope and peace from participation in prayer, meditation, worship and in the life of the faith community.

Dealing with these ultimate questions of meaning, purpose and the impending future are opportunities for spiritual growth. The provision of holistic care, which includes spiritual and religious care, recognizes this need in seniors and disabled adults. It helps society also by tapping the wisdom they can contribute.

Second, faith groups have long been aware that there are fuller dimensions and deeper understandings of the reality of community. Community is a pattern of personal relationships, economic, social and political relationships, and natural relationships which are sustained and given life by our ability to transcend ourselves and see their complexity and meaning. This pattern of relationships is vital to our wellbeing. Long-term care must be based on a vision of health that seeks to maintain the wholeness of this pattern of relationships and uses them as a resource for the provision of care.

In addition, this requires the participation of communities in making decisions that affect them, respect for the care given by families, and recognition of the needs of communities themselves. OMCSRC would hope that the new legislation does not become so centralized in one local regional office or council that there is a loss of the flexibility and responsiveness to respond to the uniqueness and diversity of the various communities.

Third, governments in Canada have recognized the importance of religion in the lives of its people. In the Constitution Act, the government of Canada recognizes the supremacy of God. Canada has been signatory to a variety of international charters, such as the United Nations Universal Declaration on Human Rights, which proclaims that, "Everyone has a right to freedom of thought, conscience and religion," which includes the right "to manifest his/her religion or belief in teaching, practice, worship and observance.

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The Canadian Charter of Rights and Freedoms guarantees fundamental freedom of conscience and religion. The Ontario Human Rights Code reaffirms this freedom. Specific provincial acts such as the Homes for the Aged and Rest Homes Act state, "An administrator shall ensure that there are adequate and regular opportunities in the homes for residents who so desire to participate in religious services."

This is even more broadly stated in the Charitable Institutions Act:

"The fundamental principle to be applied in the interpretation of this act and the regulations is that a nursing home is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."

Governments in Canada have committed themselves not only to ensure these rights in a general way, but also to enable people, particularly those under their care, to exercise those rights. The provision of spiritual and religious care is a means to honouring these obligations.

For these reasons, OMČSRC makes the following recommendations:

(a) that a stated commitment to the provision of spiritual and religious care be included in the development of new legislation, possibly in describing the quality assurance plan, and

(b) that the provision of spiritual and religious care be included and promoted as an intrinsic component of long-term care in the design of support services.

In conclusion, the religious community has long had a particular concern about the care for seniors and disabled adults, as well as for members of other vulnerable populations. In Ontario, we are fortunate to have a formal partnership between the faith groups and the government, as well as among the various faith groups themselves. This reality is not celebrated enough and has not always received the public attention it deserves.

The Ontario multifaith council is willing to work towards the delivery of improved long-term care by ensuring compassionate and sensitive spiritual and religious care that respects the religious rights of seniors and disabled adults while affirming their dignity as persons and recognizing the program needs for trained, community-supported and service delivery that conforms to agreed-to public and multifaith standards.

I might just draw your attention to the fact that we've appended to our presentation a discussion paper that was prepared for the long-term care consultation which has a longer list of recommendations, some of which may relate to the work of this committee, some of which may more appropriately relate to those who are developing the regulations in the long-term care manual. We'd also like to share those with you for your information.

I want to thank you again for the opportunity to make this presentation to you.

The Chair: Thank you very much. From the brief introductory note that OMCSRC was established in 1993, I would suspect you are probably the youngest organization to come before us, although certainly not in terms of what you do. I was not aware that had happened, so congratulations.

Rev Mr Pfrimmer: Yes. There was a new organization formed. Prior to that, it was the Ontario Provincial Interfaith Committee on Chaplaincy. So some of us have been around for a while.

The Chair: Obviously, an exciting development and I know we all wish you well. We'll begin our questions with Mr Jackson.

Mr Jackson: On that note, it's good, as a perennial social development committee member, to welcome David back. I've had occasion to receive briefs with both his monikers over the last eight years.

David, let me say at the outset that there isn't a word in your brief which I and probably all committee members wouldn't agree with you on. However, having said that, I want to move to a practical dilemma which this committee is facing. We have heard at length from single-faith-based facilities, and this presents a unique challenge, because since I have been in dialogue with legal counsel, they have shared with me and in our discussions have ascertained that for all intents and purposes, the protections and access to one's religious faith and the ability to practise it, to be able to celebrate it in your home, meaning the institution, will be protected.

However, if you read further, it also states that you have to provide that for everyone. Prior to your arrival today, I stated for the record that in no way do I think there's any great conspiracy to play with this concept. I do believe that on the basis of need, people will be asked to be placed or encouraged to be placed or told they must be placed when they are not of the same faith or cultural background or there are language difficulties, even, in terms of their placement.

Having said all that, what the law says is that the minute that, we'll say, a Catholic institution receives a Muslim, as an example, the Muslim has a right in law to

say, "I believe that my religious needs should also be met in this environment and that an effort should be made."

We know that there are two models for a response to this. One is the one that occurs in the school boards, which is, in the interests of the minority, there will be no religious instruction. That is an argument in law and in public policy, which has an effect. The alternative, of course, is that you provide the services to all.

No one's put his mind around this, but we've been sitting here listening to it and we've been discussing it and you present yourselves as a rather unique presentation representing multifaith, so I want to ask you the question: What guidance can you give us? As public policy, it could move in either direction, as you well know, because if it isn't in law a protection for a child in a school, is it any less a law of protection for an adult?

Rev Mr Pfrimmer: I think there's two dimensions to your question. Let me start with the first one. There's first the right to have access to your own faith group and faith community, and I think you're pointing out in one case that is certainly something that's guaranteed.

Moving to the more public dimension, how you provide services to a multifaith constituency, I think Ontario is somewhat unique in that. I think it's been since the 1970s, 1972, when we started this process. One of the things that's interesting is that the faith groups came together and said, "How do we make sure that people have access to that and how do we provide and facilitate that access?" That's in a sense what many of our chaplaincy programs are about, to ensure that those who may have no faith community who need some services can avail themselves of it.

But secondly, for those, for example, who have a particular faith tradition who want to relate to that tradition and that service may not be there because there's not a large community in that part of the province or whatever, one of the commitments is that we will make sure they get access to those kinds of people they need, whether it's a priest or a rabbi or an imam or whoever. So in some sense there's a facilitation role that can be provided.

I'm not sure if that gets exactly at your question. It doesn't.

Mr Jackson: No, and I'm sorry, David, not at all. In Ontario we have embraced the notion that seniors and their faith should be one and the same, and we have moved in a direction of exclusivity, not inclusivity. Therefore, religious faiths, whether they're language-based as well or culturally based as well, but essentially these are religious-based institutions, have been allowed to meet the needs of the citizens, and in 99% of the cases their admissions are for persons of the same faith, and they go for that reason.

What I was suggesting to you is that in Ontario in the next decade, for reasons that come from the bill and the practicality of life in Ontario, it would appear that we may have to say to those institutions, "You must receive 10% or 20% of your residents who do not share that faith." I don't want to march you off on a branch here where we talk about the board of directors now saying, "Well, why should we contribute?" Those are all the statements we've heard and received up to this point.

What I'm basically asking to you is, according to the law, the law will ultimately fall on the line that it's not that your access to your faith is protected in a nursing home or a home for the aged, but that you can no longer practise exclusively in one capacity, in one faith. That is a legal response and I don't wish to quote at length all the court cases, but I cite for you the most contemporary example, which is the removal of prayer in our schools. I don't wish to debate that; I'm just simply saying that has, as its genesis, a point in law which flows from our Human Rights Code.

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I'm sorry to be giving you such a challenging question, but you're the first individual in my six weeks on this committee to whom I've felt comfortable in posing it as a question, because it is a significant policy question which no one, as yet, has dealt with. But it essentially could occur as a ruling from the courts and/or a ruling from an interpretation. This is causing unnecessary and undue uncertainty out there.

But it begs the question, can exclusive faith communities that provide support for seniors continue in that capacity, or what will be the ultimate response to that? You may not have the answer and may wish to just meditate on that and get back to the committee, and that would be helpful. But I would feel better if I was able to share my concern with somebody for the record, because I see people out there worried about this. We're trying to get a finger on it, but when I talk to the lawyers, they tell me this is a very real concern.

Rev Mr Pfrimmer: We did have some discussion about that. If you look in the discussion paper, I think on page 6 there's probably a longer section; I may not be able to put my finger on it right away. But one of the concerns is obviously that if you have a faith group which has an institution that originated to provide care for people from the community as they reach their senior years, how do you not undermine the momentum and motivation that creates? Quite frankly, the public gains a lot by the kind of volunteer work and charitable giving that often supports those institutions in less direct ways.

So we've had some discussions about that briefly. I can't give you the final answer, but I can say this: One of the things the committee needs to be very careful of is that it may end up with a two-track approach to some of these situations. This is a personal observation, but I have not, in my experience, heard anybody say that they want to exclude folks from those facilities. In other words, if someone comes forward who needs care, at least most of the religious traditions are very open to that. Where the problem would occur is if it becomes so rigid—and I think that was referred to in my comments here—that another outside body is making those decisions of who gets in and who gets out, without any consideration of the community character of those institutions. Then you're going to run into major problems; it's going to be counterproductive.

The point would be, then, that there has to be maybe a bit of a two-track approach to this overall, that one has to respect the character and uniqueness of those institutions, realizing that they probably will be open to accepting people, because obviously bed spaces are at a premium.

Mr Jackson: I wish we had more time. I appreciate the indulgence of the Chair. I would like to talk to you after this is over because I want to pose a couple more questions to you privately, if I may. Thank you very much.

The Chair: Thank you. I think it is an important area.

Mr O'Connor: I want to thank you for coming and making your presentation. As Mr Jackson's been saying, we have heard from different people in the faith community who actually have their own home that they've established and have a community that they direct their service at and quite well. As you say, there's a whole network of volunteers that does evolve around that. It's not the intention to take away from that. You've certainly given us an opportunity here to take a look at where you see we might be able to bring this into the legislation, recognizing people's rights.

I know that in the church I go to, on Sundays at our service we have a minister of the eucharist who leaves the church and goes to the nursing home or home for the aged to bring that into the home that the person's living in. Most homes for the aged or nursing homes, if they're approached to take a look at the spiritual care that is required for the residents, in most cases try to accommodate, regardless of whether or not it's one of the religions that perhaps developed the care facility.

So I guess I really don't have a question for you; I just want to thank you. Maybe where you've stated we can put this might not be the appropriate place—because we've had some good discussion in this committee about the quality assurance plan—to put in a statement recognizing the needs that you pointed out to us; maybe it's some other spot. So I just want to thank you for that suggestion, and you certainly pointed out a need to us. If you have any comments—

Rev Mr Pfrimmer: Just one, and I suppose we're not firm on putting it in the quality assurance part of the legislation. I guess what we are concerned about is that it's stated somewhere, because if it's not stated, what tends to happen is it becomes a little bit haphazard. It also becomes vulnerable to a lot of very diverse interpretations which are not always in the best interests of the people within the institutions. I think what we're trying to do is offer a suggestion but also offer some help in terms of that in Ontario we have the mechanism, in fact, to ensure that this is done in some affordable and mutually respectful way. I think that's a clear point. So if there is someplace else that it could be inserted, that would be very helpful, and then as the regulations are worked out, I think some of those dimensions can be put in. We have in fact sent materials off to those who are tentatively looking at some of those issues now.

Mrs O'Neill: Rev Pfrimmer, have you been part of the advisory committees at all, or have you just made your presentations to these legislative committees on these hearings?

Rev Mr Pfrimmer: The advisory committees in terms of?

Mrs O'Neill: There've been a whole lot. As you know, there are statements made by the government that

this has been the most heavily consulted piece of legislation in the history of Ontario, much of which I have exception with. Have you been part of that consultation at all?

Rev Mr Pfrimmer: Yes. We've been part of the consultation. To my knowledge, there were a couple of advisory committees, one on palliative care I think, that we've also made some interventions on as well. So we have been part of the consultation although we've been a little bit uncomfortable with how the material after we present it comes out. I suppose our discomfort comes in the sense that people treat it almost like every other service, and I guess our point here is that it has to be distinctive in some sense.

The same thing happens with volunteers often in institutions. We have people who are volunteers in an institution, who come in to provide a kind of service from their community or faith group, and end up being treated just like all the other volunteers who do different kinds of things. In fact, many of them end up in other capacities, and we're just saying that there needs to be a recognition of the distinctiveness of these two dimensions.

Mrs O'Neill: I'd like to read into the record, if I may, a couple of things from your previous brief, because you didn't have a chance to do that today. I think you made a very strong recommendation, which I totally agree with. "A stated commitment to the provision of spiritual and religious care be included in the development of new policy documents" was presented by you today. But you in the past, in a previous presentation, had said, "The distinct religious and cultural identity of long-term care institutions owned and operated by faith groups be recognized." That statement, although not said in those exact words, has been presented to us by many people across this province even as late as today.

The word "spiritual" was used in this committee today, and I'm very happy actually, by the parliamentary assistant. The word "spiritual" hasn't been around much in these discussions, and I think you've noticed that.

The other thing from the past that I'd like to put on the record that you have brought forward, "That spiritual and religious needs be part of the client assessment process and that the new standards of care include the provision of spiritual and religious care," and "That spiritual and religious needs be part of the client assessment process."

I think you know as well as I that in the social planning councils of this province there have been many very significant inputs by the religious of the communities where social planning councils have been successful, and those have been ongoing for 20 to 25 years.

I think the same role should be played by the placement coordinator. You in your brief and I in my comments for a long time have talked about, what do we mean by "community"? I don't know what we mean by "community." I still don't after sitting on this committee since day one. A faith community is one, and you're very much part of the general community whether it be neighbourhood, whether it be linguistic, whether it be cultural. All of those things are left to be decided. I still hope that we can somehow guarantee the placement coordinator, whether it's one person or a group of people, is not going to work in a vacuum,

because many of the placement coordination agencies that are existing in the province right now, as you know and I know, have got advisory boards and/or a board of governance of some kind, and that's where I think you will need to fit in

I wanted to ask you if you've seen the draft document, the Long Term Care Facility Programs and Services Manual, draft 1 or draft 2. Have you seen that?

1730

Rev Mr Pfrimmer: We saw draft 1, and I think I sent, in a letter to the chairperson of the committee, a list of our detailed response to all the various dimensions of that.

Mrs O'Neill: I think you should see draft 2. I hope it's available to you today. If not, we have received it as of today.

Rev Mr Pfrimmer: I see it coming.

Mrs O'Neill: I feel very strongly that you will want to have input into it. I am quite disappointed that the words concerning faith are still lacking, because we have had this from every faith, and your group is so representative of all faiths that I decided to make these comments. You might be happy to know that you're not the first group of religious that ended our day, because in Kingston we had the chaplains end our day and, as you know, they have a very strong organization of pastoral care. Many of us on that committee that day expressed how important pastoral care has been to us as families and to our relatives who have been facing some very difficult decisions as they grow older.

So I thank you. I'm pleased the day has ended this way. I think you need to keep speaking very clearly. I find your comments very clear and I have no questions other than the ones I posed.

Rev Mr Pfrimmer: I think, basically, I want to thank you for that, because certainly that was our concern with draft 1, for example, of the document, that it had been purged of religious language. I think a lot of people think freedom of religion is really—I mean, it has become almost freedom from religion rather than freedom of religion, and I think we need to look at that.

We are very fortunate in this province to have a level of cooperation among the various faith communities in this that is really exemplary in terms of North America and, I would suspect, many other countries as well. I think that's a resource that's available and a partnership that has been established formally that can be utilized.

In terms of your comments about the notion of community, I think we need to move to a more sophisticated notion of what community is. People are part of multiple communities. I think that would be our point. The sort of nuclear community where everybody does everything together and all the relationships are cut and dried no longer exists, but that's not something to be frightened of. That's probably something to feel fortunate for, recognizing that it introduces new dynamics that may be a challenge but certainly ones that we can work with in a creative way. So thank you very much for your remarks.

The Chair: Thank you. The parliamentary assistant wishes to just note something from the manual.

Mr Wessenger: I would just like to note from page 8 of the manual. It states: "Residents shall be supported and assisted in maintaining their preferred spiritual and religious observances, practices and affiliations both within the facility and in the community."

The Chair: Thank you. If I might, on behalf of the committee, I thank you for coming and for speaking so strongly to the spiritual aspect not just of seniors' lives but all lives.

In the last number of years in my own area, Rev Albert Revell worked in putting together a book for laypeople working with seniors in institutions and in the community which we circulated to all members of the Legislature. What we found and what I was struck by was the number of responses that I then received from members of all parties indicating that people had been asking: "Is there something for laypeople who, when they're working with seniors in institutions and in the community, are finding that need is there and not knowing quite how to respond to it?"

I just think that whole question, and certainly the point that Mr Jackson was making, is that it's an issue, that spiritual and religious side of lives, where we almost don't seem to want to really talk about it. As you say, it almost becomes freedom from. I've heard it expressed as a marginalization of the religious or the spiritual part of our lives. In some ways, seniors drive that point home more dramatically as we work, whether it's with our parents, other loved ones or people whom we meet in institutional

settings. I just think you've raised a number of issues and that we as legislators, regardless of political party but as legislators, must try to find other ways of recognizing that that's a valid part of our lives. We thank you very much for coming.

Rev Mr Pfrimmer: If I might just say for the other members of the committee that we have two resources that are in the works. One is a multifaith packet that gives a bit of a summary of the various dimensions, the various faith groups that participate in the multifaith council. You may like to get a copy of that. I know the provincial coordinator's office for chaplaincy services has those.

We are also in the process of developing a policy manual which will be useful not just for chaplains serving institutions and government programs, but also looks at ways of building bridges between the faith communities, how to utilize those resources, particularly in institutions where they may not require a full-time chaplain or there may be a community-based program. You may want to keep your eyes open for those two resources as a kind of helpful thing to detail some of the ways in which we do it in a formal way in this province. Thank you very much.

The Chair: Again, thank you very much. With that, the committee stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1736.



Substitutions present / Membres remplaçants présents:

Carter, Jenny (Peterborough ND) for Mr White

Hope, Randy R. (Chatham-Kent ND) for Mr Drainville

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer

Jamison, Norm (Norfolk ND) for Mr Martin

O'Connor, Larry (Durham-York ND) for Mr Gary Wilson

Sullivan, Barbara (Halton Centre L) for Mr Daigeler

Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Also taking part / Autres participants et participantes:

Haeck, Christel (St Catharines-Brock ND)

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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Official Report of Debates (Hansard)

Thursday 11 March 1993

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Jeudi 11 mars 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Président : Charles Beer Greffier : Douglas Arnott

Chair: Charles Beer Clerk: Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 11 March 1993

The committee met at 1009 in committee room 1.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen, and welcome to Thursday, March 11. This is the meeting of the standing committee on social development to review Bill 101, An Act to amend certain Acts concerning Long Term Care.

SUNNYCREST NURSING HOME

The Chair: Our first witness this morning is from Sunnycrest Nursing Home. We welcome you to the committee. If you would be good enough, first of all, to introduce yourself for Hansard and for the committee members, then please go ahead with your presentation. We'll follow up with some questions.

Mrs Jean Forrest: My name is Jean Forrest. I'm the administrator of Sunnycrest Nursing Home in Whitby, Ontario. I'm glad to have this opportunity to speak to you on behalf of the residents and the staff of the nursing home.

Sunnycrest is a 136-bed facility. It has been owned by the present owners for 25 years. It was originally a large house and we added on to it in 1971 and then again in 1983. At that time, we upgraded all of the facility and added a respite bed. We're a large, modern facility. We're located on three floors, we have no structural deficiencies and we're in compliance with all regulatory bodies.

I joined the staff in 1983 as director of care, and I've been administrator since 1985. I'm a registered nurse. I have a certificate in gerontology and a BA in health services administration. I'm a member of the Durham region placement coordination committee.

The staff of our home were awarded the Ontario Nursing Home Association staff achievement award for the care college in 1987, where our residents attend courses, receive credits and then they're given a certificate. We're respected in the community for the level of care that we give our residents. We were awarded accreditation status in 1984 and we've remained accredited ever since. We received a three-year award in 1986, in 1989 and in 1992. All of our residents are extended care level. Our average age of residents is 85. We have 120 staff. Most of them are organized under CUPE. We have a strong volunteer group and numerous educational and community groups use us for work

placement projects. I hope that gives you an overview of where we're coming from.

I'd like to address, in Bill 101, the following areas: the service agreement, placement, inspection process, quality assurance and plans of care.

The service agreement is crucial to the functioning of any home, and for us particularly. Through it, funds will flow, programs will be provided and therefore care will be determined, but we have not yet seen this document. We're expected to move from a system of funding per bed to a system of funding for programs which we will agree in advance to provide, but we're not told what dollars are available to fund these programs. It would appear that we're to state what we are intending to provide to our residents without knowing if we'll be able to pay the staff who will be required to deliver the care.

We recognize that as more and more people elect to stay at home, being cared for by community programs, the person who will need our care will require more levels of care that at this time we don't provide; for example, catheter care and oxygen therapy. This care has not been part of our philosophy, as these care needs can only be met by registered staff. Our present funding does not allow us to increase the number of registered staff. The government has indicated that the homes will provide this level of care, but we have not been assured that adequate funding will be provided to enable us to increase that level.

We are caught in a dilemma. Do we say we will provide this care, trust that funds will be there, or do we face reality and say that because we don't know what funds are available, we're unable to provide the care? Should we state that we cannot provide the care, where does that leave the residents in the community who need long-term beds and we can't meet their needs? It would appear also that if we don't find an agreement, we'll no longer be a nursing home. We must know what funding will be available for each level of care before we can make an informed decision as to what care we are going to provide. These decisions need to be made before we can sign the agreement.

Our strategic plan foresees us being a community resource providing programs to meet the needs of the elderly. We could provide wheels to meals, Meals on Wheels, day programs, podiatry clinics. We could share our physiotherapy and our pastoral care services. We could coordinate staff providing care in the community. We can provide any level of care that we can train our staff to give. Our ability to train will, of course, depend on the funding available.

Bill 101 indicates that placement to long-term-care beds will be controlled by a placement coordinator, but this coordinator has not been identified. It raises concerns for us, as placement is crucial to our ability to provide care. The coordinator has been given the sole power to determine who will be eligible for a long-term care bed.

There is an avenue of appeal open to the family should they disagree with the decision. Mention is made of final appeal to the courts. I wonder who will bear the cost of this. Does this mean that families who couldn't bear the cost would not be able to appeal?

There is no avenue of appeal in this bill for the homes.

We may have very grave concerns with the care needs and the ability of that person who is coming to us to fit into the bed or the area. Persons are not being placed into an empty house; they are being placed into the home of 135 other people. The home must have a voice that this placement is suitable before the placement is made. The needs of those already placed must be taken into account. We must be able to make our voice known.

The fact that a person is deemed eligible and is the one who has top priority is not all that's required to make a suitable placement. Human beings are complex. They cannot be reduced to a few pages on an application form. The home and the placement coordination service must have the freedom to work as professionals, as a team, for the benefit of all residents, those already in the home and the person seeking placement.

The present system that we have in Durham region of placement coordination service works well for us. In this system, the family has a choice of where they would like to be placed. I don't see that choice evident in Bill 101. We stress the need for avenues to be identified where those awaiting placement can have their choice known and honoured.

We are now in a state of crisis. Our residents are growing older. Some of them have lived with us for more than 20 years. The residents we are admitting have remained longer on community supports and require more care, but we have not received funding to address that problem. Our staff are asked to give more and more and to work for less money than other sectors are providing. We are paid \$77 daily and the government knows that it takes \$120 daily to keep a resident in a municipal home.

Who bears the brunt of that inequity? Our residents do. These are the same ones who paid the same taxes as the people who live in a municipal home. The court case that the Ontario Nursing Home Association brought forward identified that this inequity does exist, but Bill 101 does not appear to identify any strategies to correct this. In fact, it appears to allow that some homes can be funded at different rates than others. Where does that place the vulnerable elderly person who is placed in a home that's not funded to provide the same care as another home?

Our staff are the other ones who are affected by this inequity. They're being asked to do more and more, when funding to address the levels of care is not forthcoming. The Ontario liquor board pays staff more to stock bottles on the shelves than Ontario pays to have its elderly looked after.

Too long have you used the excuse that the private sector should not be funded because it makes a profit. Mechanisms are in place to ensure that funds are directed to specific areas. Financial statements are filed with the

government annually. We post them for public viewing. Business taxes are paid to municipalities. GST and PST are paid to the respective levels of government. Buildings are erected and maintained without government investment.

The government has recognized the need to continue to use the private sector in providing care to the elderly. It's the government's responsibility now to ensure that these elderly receive equitable care.

It has taken many years of collaborative effort by the Ministry of Health and nursing homes staff to reach the present level of respect and trust that is exhibited between the residential services branch and the homes. We are not adversaries in providing care to the elderly. Homes and ministry want the same thing: to meet the care needs of all aspects of the resident's life and to provide this care in a safe and comfortable environment.

Why then does this legislation revert to the use of inspectors, when we have already achieved the compliance program? That program was put in after the government's own study by Woods Gordon.

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Care givers in the homes are, in the majority, people who desire to serve the elderly. Their jobs are not easy; in fact, they've got very difficult jobs, with many stresses. We have policies and procedures in place the meet the requirements of the Nursing Homes Act, the health and safety act, the food premises act, the fire code, and I could go on and on. Staff are required to adhere to all of these while they deal with the very particular needs of the frail elderly. It's extremely demoralizing to know that an inspector is in the building reviewing the work they're doing.

Please continue to use the compliance system, where staff are able to communicate. Residents are better cared for by staff who feel appreciated rather than the focus of inspections.

Bill 101 refers to such systems as quality assurance.

Nursing home administrators are required to be licensed and to have a certain level of education. Most homes are accredited. All homes are monitored by the compliance management program. Surely these systems will ensure that high-quality management systems are in place. There is no need to identify specific management systems in regulation. Identification of such systems will actually hamper the natural evolution of good management processes. For example, Sunnycrest has had a quality assurance program in place since 1985. This has further evolved through quality management, and at present we have a program of continuous quality improvement.

We believe that the government should set systems in place to identify the care it requires and have systems that monitor whether that care is being given. The management of the facilities should be left to the professionals who are qualified to do it.

As with quality assurance, we find problems with identifying plans of care in legislation. The act specifies that residents will be cared for by registered staff. Registered staff are professionals. They're regulated by the College of Nurses and, as such, they must develop a plan of care for any person they care for. Government really should take a leaf out

of its own book and use quality management processes which will empower the professionals to do the job they're qualified to do.

Bill 101 has set out many sanctions that can be used against a home, without identifying any accountability for those who have the power to enforce the sanctions. There's little evidence that the residents have been given any avenues to strengthen their voice.

The tone of this bill infers that homes are adversaries of the resident, when the reality is that nursing home staff, at every level, hold the resident in high esteem and want to give the best care possible. We can only do this when the government recognizes the needs of the elderly and provides equitable levels of funding to enable us to meet those needs.

Thank you for this opportunity to make our concerns known.

The Chair: Thank you very much, Mrs Forrest. You mentioned to me at the beginning that this is your first time before a committee. If everyone who came before a committee for the first time put the work and effort into the presentation that you clearly have made, I think we would be a lot better off. We thank you for your first visit, hopefully not the last. We'll begin questioning with Ms Sullivan.

Mrs Barbara Sullivan (Halton Centre): I too appreciated this brief. It really addresses the pragmatic issues that are facing nursing homes and indeed homes for the aged across the province, because they are working in an atmosphere that is basically one of a lack of knowledge and a lack of information about which to plan. Therefore, my questions are going to be to the parliamentary assistant. I'm going to ask him, first of all, what funding will be available for each care level, and when homes will be informed of that so they can draft their budgets and prepare for the case mix index within their own properties? What funding will be available to enhance the skills of workers in existing homes to perform the services which now will be not only allowed but perhaps mandated in homes, and must all homes provide those services? Ms Forrest has indicated two or three areas of increased service which are not required everywhere. Third, who will cover the cost of the appeal, and will intervenor funding be available? Is that contemplated?

The Chair: We have the parliamentary assistant.

Mr Paul Wessenger (Simcoe Centre): Unfortunately, ministry staff has not heard the questions. I'll address the first question and refer to staff, because the first question involved the funding. As we know, there's the general overall funding of \$206 million for the facility sector.

Mrs Sullivan: I think the interest was in the level of funding for each care level as it's identified on the case mix index.

Mr Wessenger: I'll ask ministry staff to indicate that.

Mr Geoff Quirt: Geoff Quirt, acting executive director of the long-term care division. I have to say that for the record at the start of each day.

The Chair: We just want to make sure you know who you are.

Mr Ouirt: Some days, I'm not sure.

The funding will be provided through three components in the three-part funding formula. The funding that's available will be the funding currently provided to nursing homes and homes for the aged plus \$206 million generated through the redirection of long-term care. That funding will be divided among facilities in the following way:

All facilities will receive a fixed rate for providing accommodation services. That rate is yet to be finalized but will be more than \$38 a day, which is what the residents will be requested to pay if able to do so based on their income. There will be a second amount of money that will be a fixed amount of money, provided on a per-client, per-day basis, that will be available for quality of life programming. Because there's no accurate way to measure someone's need for spiritual care, recreation, physiotherapy or occupational therapy, that funding will be provided on a per-client, per-day basis.

Mrs Sullivan: Do you know the level of that funding, Mr Ouirt?

Mr Quirt: No, we don't at this point. I'll explain in a moment how we'll arrive at that level of funding. The third category will provide funding based on the nursing and personal care requirements of residents. That funding will vary in accordance with the actual care requirements of people in each facility, and it will be varied by comparing one facility to all other facilities in the province through a system of case mix indices.

Following completion of the estimates process within government, we will confirm how much funding is available in the base budget for nursing homes and homes for the aged, a process that happens each year. We will then calculate the average funding for each individual facility, and we will then take the case mix index for each facility and vary that average upwards, if its care requirements are higher than the average, or downwards, if its care requirements are lower than the average.

It's expected that we'll be meeting with our funding working group towards the end of March to present it with the funding available, how the average is calculated, the average case mix indices for each different category of care in our system and the individual case mix index for each particular facility. It will then be a matter of simply calculating the formula for each facility, and each facility will be able to know exactly what its funding would be in each of the three categories.

We will propose, at that meeting, to representatives of the Nursing Home Association, the homes for the aged association, Concerned Friends, residents' councils and representatives from organized labour, how the funding available might be divided up among those three categories: accommodation, programming and nursing and personal care.

We expect to get feedback and have some dialogue on the distribution of those funds before a final decision is made. We don't want to make an arbitrary decision, without having some discussion with the people affected, on how the overall funds might be divided into those three categories. That's expected to happen towards the end of the month, around April 1, depending on when the estimates process confirms the amount of money available for 1993-94.

Mrs Sullivan: The second question related to what funding would be available to enhance the skills of workers, and whether all homes must enhance their staff to ensure that the additional medical treatments which will be allowed in homes are delivered in each home.

Mr Quirt: Yes. Funding for training will be a legitimate cost in the program component of the budget as well as the nursing and personal care component of the budget. In other words, expenditures related to sending a worker on a course or bringing in an expert for in-service training will be a legitimate expense in spending the money that's allocated to each facility for nursing and personal care or quality-of-life programming.

In addition, as an aside, the government's palliative care policy will fund the training of a staff person from every nursing home and every home for the aged in Ontario in learning more about how to appropriately deliver palliative care in long-term care facilities. That's a separate initiative I thought I'd mention.

There will be a requirement for increased RN coverage in our long-term care facilities. I mentioned before that currently there's no requirement for 24-hour RN coverage in nursing homes. That will be a requirement in the new system.

There will be some latitude for each facility to decide, within the funding provided for nursing and personal care, the most appropriate staff mix to meet the needs of their particular residents. Some facilities may opt to have more RNAs, others may decide that they'd rather have more health care aides, and others may decide that more professional staff would be a more appropriate expenditure from the funding available for nursing and personal care, if there was a requirement that their residents had for a higher-than-usual degree of interventions that required an RN service.

Mrs Sullivan: I think the second part of the question is whether you will require all homes to have skilled workers and the capital facilities that are required sometimes for, by example, oxygen therapy and catheter care, which are in a different situation now under the Nursing Homes Act.

Mr Quirt: We would require that there be RN coverage on a 24-hour basis in all long-term care facilities, and we would require that before oxygen therapy or catheter care were delivered, the facility staff receive the appropriate training and develop the appropriate policies and procedures that their facility would need to ensure that they deliver that in a safe way.

We'd also provide whatever consultative support from our compliance advisers and our nursing consultants that might be necessary for a facility to upgrade its skills. I'd qualify that comment by saying that the RNs who work in our long-term care facilities are professionals; they may need some refresher courses in some cases, but I think they are as up to the job as the nurses who do those services in

people's own homes and have been doing that for the last 15 years.

The Chair: Mrs Sullivan, we're going to have to move on.

Mrs Sullivan: The last question was intervenor funding for court appeals, to cover the cost of the appeal.

Ms Gail Czukar: Gail Czukar, legal counsel with the Ministry of Health. Did you say intervenor funding or just funding for appellants and so on for the placement coordination appeal?

Mrs Sullivan: One or the other. Have you considered either?

Ms Czukar: We've considered approaching legal aid about legal aid certificates. In any event, legal clinics would be available to assist people whose incomes are at a level where they can't afford their own legal counsel, as they are now for the current appeal.

The Chair: Mr White.

Mr Drummond White (Durham Centre): Good morning, Jean. How are you?

Mrs Forrest: Fine.

Mr White: I'm very impressed, as you know, with your facility and the quality of care you've offered, the acuity and the knowledge that you have personally and your advice. The first time I was there, of the many times I've been there-my assistant even offered a course at your facility-I met with a number of nursing home administrators, vourself included. You all have practical problems, and I think you bring up a lot of those things: Here's the law, but where's the money? I think that's a lot of how you operate. You want to be able to offer the best possible care, but when I met with you and Ivan and a number of other people from this whole area, from Richmond Hill through to Cobourg and Port Perry, one of the main issues you were bringing up was the inequity in funding, that municipal homes for the aged receive more money on a day-to-day basis than nursing homes. Under this bill, if you're a long-term care facility, whatever act regulated you in the past, you would be receiving the same level of funding for care.

Mrs Forrest: That has not been stated.

Mr White: It hasn't. Okay. That's certainly one of the things the nursing home association was very pleased about. I think it's fairly clear in the act that we're bringing together those different pieces of legislation so that there's a fairness and an equity brought about.

Mrs Forrest: I agree. I see steps in that direction, but we have not been told that we will receive the same funding as homes for the aged.

Mr White: On a daily basis. **Mrs Forrest:** On a daily basis.

Mr White: I think that's a really practical consideration I think we should deal with.

You're also on the placement coordination committee, locally?

Mrs Forrest: In Durham region, yes.
Mr White: How is that service working?

Mrs Forrest: It works very well for us. I think definitely, rather than create another system, that system could be utilized.

Mr White: That's the system that would be utilized. As you say, rather than creating another system, all you do is fund what we already have to make sure it keeps on going. You have a pretty direct feed into that, being on that committee

Mrs Forrest: Yes.

Mr White: Okay. So you're satisfied that if the funding went to that placement coordination committee in Durham, those decisions would be reasonably palatable for your facility.

Mrs Forrest: They would be, but we still need a voice

Mr White: You'll have that voice. You're actually still on the committee.

Mrs Forrest: Well, yes and no. We need a voice to be able to say that yes, this person seems to be requiring our care and yes, this person is the first person priority, but the room that this person's about to go into has X, Y and Z and that person will not fit in. We have to be able to say no to some people.

Mr White: That's the appeal issue, and I think it's a very valid point.

I want to thank you for coming and for bringing forth those very practical, humane and professional concerns. Could we just get a clarification on that one point Jean's still concerned about, that there would be an inequity of funding on a day-to-day—

Mr Wessenger: I understand it's been made clear on many occasions that the level-of-care funding will be the same for all institutions except for the exception. I think that is what the presenter may be referring to, the fact that some of the high-cost ones will be red-circled. No institution is going to have its funds reduced. In a sense it is not going to be actual equal dollars to all institutions, but everybody's guaranteed that equality with respect to the level-of-care funding.

Mr White: But a facility like hers would not be red-circled. She's at the bottom of the heap.

Mr Wessenger: That's right.

Mrs Forrest: Are you saying, then, that we will be funded to bring our quality-of-care programs, including social workers, physiotherapists, pastoral care people and all the other persons who are now in place in municipal homes in place now?

Mr Wessenger: No, I think that's-

Mrs Forrest: What I see then is inequality.

Mr Wessenger: As I say, there are some homes for the aged that receive more money than they would be entitled to under the levels-of-care funding.

Mrs Forrest: I know what you're saying. What I'm saying is that my residents deserve the same care as residents in a municipal home. They deserve to have the same programs available to them, and that takes money.

Mr Wessenger: I understand. You've made your point.

The Chair: Your point is clear. Again, on behalf of the committee I want to thank you very much for coming down this morning and joining us.

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ONTARIO DENTAL ASSOCIATION

The Chair: If I could next call on the representatives from the Ontario Dental Association, if they would be good enough to come forward.

Mr Cameron Jackson (Burlington South): Mr Chairman, I anecdotally referred to Martha and Mary. Just for the record, that was a campaign done by the ONHA to demonstrate that Martha lived in a nursing home and Mary lived in a home for the aged and that their care needs were the same. It was an interjection, but for the purposes of Hansard, I'd like to clarify. The deputant understood the reference and agreed with it.

The Chair: Thank you.

Welcome to the committee. If you would be good enough to introduce yourselves for Hansard and for the committee members, then please go ahead with your presentation. We have a copy of your brief in front of us.

Dr Aldo Boccia: Thank you. I'm Dr Aldo Boccia, a general dental practitioner in the province of Ontario, and I'd like to thank the Chairman and members of the committee for giving me the opportunity to speak to you about Bill 101. I am also a member of the health care committee of the Ontario Dental Association. With me I have Linda Samek, who is director of professional affairs for our association. She is also serving on the health care committee of the Ontario Dental Association. We are here on behalf of the Ontario Dental Association, which represents more than 5,000 dentists. Our comments today will focus on two key areas: access and funding.

The mission of the Ontario Dental Association is to support its members in the delivery of exemplary oral health services to the residents of Ontario. Unfortunately, there are a number of barriers which restrict our ability to serve the oral health needs of the long-term care population. We trust that new legislation will eliminate these barriers and enhance access to needed dental care for this special population group.

As you know, the current Nursing Homes Act recognizes that dental care should be available to the nursing home resident. Here, the physician attending the resident informs the administrator that the resident is in need of the service of a dentist, and the administrator arranges with the resident to receive services at their own expense.

Despite recognizing that patients may require dental care, there is no corresponding requirement to provide ongoing regular dental care to this patient population. Neither the Charitable Institutions Act nor the Homes for the Aged and Rest Homes Act requires that routine dental care be provided on an ongoing basis. Thus, patients within Ontario's long-term care system have only a theoretical right to needed care on a timely basis.

In June 1992 the then Minister of Community and Social Services, the Honourable Zanana Akande, reported on a redirection of long-term care. According to the minister, a fundamental principle to be contained in the policy framework was a patient's right to fair and equitable access to appropriate services, so that people who use the services can make informed choices.

Today's ad hoc arrangements for the delivery of oral health care to this special patient population are not in keeping with the principle of equitable access outlined by the ministry, and the legislation that we see in front of us does not guarantee that those within the long-term care system will have access to dental care.

We are pleased to see that the plan of care outlined in all three sections of Bill 101 recognizes the need to provide for a continuum of care, but based upon our experience within the long-term care system, we believe there is a need to clarify which services will be available to these patients. In our view, it is not good enough to say that the regulations will address this matter. We ask for your commitment that revisions to current legislation will guarantee access to dental care on a regular basis for this special patient population.

If the facilities referred to in Bill 101 are going to ensure that they assess and provide for the "requirements" of each resident on an ongoing basis, there must be a mechanism in place to work with the dental profession. We stress that we cannot simply leave it to the physician to recognize that dental care is required. The physician is not educated and trained to diagnose and treat the full range of oral health conditions. Thus, the coordination and provision of a plan of care will require consultation with a dentist.

Once again we emphasize that our goal is to eliminate the hurdles that patients must cross to obtain needed dental care within today's long-term care system. Enhanced access to a broad range of oral health services will benefit this at-risk patient population.

We agree with the comments outlined in the consumer report on long-term care reform that there is compelling evidence that poor oral health has a direct impact on the physical and mental health of seniors. The ODA wants to work with all interested parties to ensure that the impact is positive for those with physical disabilities, chronic illness and the elderly within the long-term care system.

Funding remains a major barrier to accessing oral health services for this patient population. Therefore, it was with great pleasure that the ODA read the June 1991 statement from the Ministry of Community and Social Services announcing, "Quality care will be affordable to all, regardless of their financial situation." Even though this announcement reported that money would be added to the budgets of existing nursing homes and homes for the aged to "ensure that the ever-increasing care requirements of residents can be met effectively," there was no corresponding announcement about what care requirements were to be met. Now, nearly two years later, there is still no clear direction about the range of health services that are to be provided for the long-term care patient.

We have stated here that the ODA believes that oral health care should be included among the core programs available through the long-term care delivery system. At the same time, without appropriate funding mechanisms, many of these patients would be forced to delay needed dental care. As a private practitioner, I can tell you that many dentists frequently arrange to ease the financial burden an individual senior may face. None the less, such ad hoc financial arrangements are not an appropriate alternative to a province-wide funding program designed specifically to meet the needs of this special patient population.

Because the elderly comprise a significant portion of those within the long-term care system, we want you to know that the ODA developed a strategy to implement a dental plan for Ontario's elderly. When we shared our proposal with the Ministry of Health in 1987, we noted that we understood that it was "essential that attention be paid to the need to develop a program Ontarians can afford." While we encouraged the ministry to provide dental benefits to all seniors in Ontario, we recognized that financial constraints may not permit the immediate implementation of a universal program. Therefore, we agreed to support, at a minimum, a program that would provide benefits to those confined to institutional settings and seniors receiving guaranteed supplement.

To date, the government has not introduced financial assistance for dental care provided to our seniors or others within the long-term care system. This reform process provides each of us with the opportunity to review the allocation of funds.

Because this new legislation will prescribe maximum amounts to be charged to designated services, the ODA wants to offer our assistance in establishing professional fees for dental care. The ODA has considerable experience in developing and maintaining the dental fee guide and designing dental plans, including cost containment plans. We look forward to the opportunity to explore funding issues with you in more detail.

In summary, we want you to know that our concern about the delivery of oral health services to the elderly, the institutionalized and homebound is long-standing. It is because of our experiences within the current system that we emphasize the need for new legislative initiatives. We are particularly pleased that the Senior Citizens' Consumer Alliance for Long-Term Care Reform recognized that "Oral health care services are an integral component of long-term care and urgently need to be put in place." We could not agree more. The ODA wants to be involved in developing solutions to today's problems.

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As a profession committed to the delivery of exemplary oral health services for Ontario residents, the ODA has established a network of subcommittees in each of our 38 component societies. These special patient subcommittees are prepared to work with all stakeholders in their communities in an effort to enhance access to dental care for this population of elderly, disabled and chronically ill patients. Some societies, including the four Toronto societies, have purchased a complete mobile dental unit, which can be utilized by our members on a rotational basis. In short,

we are willing and available to provide care within the long-term system in communities right across Ontario.

In our view, those who have contributed so much to society should not be denied access to regular and ongoing dental care. It's important that we work together to develop comprehensive legislation designed to enhance a full range of services on a routine basis.

I thank you again and I will be pleased to entertain any questions you might have.

The Chair: Thank you very much for coming today and sharing those thoughts with us. We'll begin the questioning with Mr Jackson.

Mr Jackson: Thank you very much, Mr Chairman. Aldo, welcome and thank you for your brief. I cast my mind back to the last three provincial elections and I seem to recall a couple of political parties promising geriatric dental plans for Ontario.

Dr Boccia: Yes.

Mr Jackson: We seem not to be any closer to it, but we've never had a better opportunity in the last decade to merge the medical needs of seniors with reform.

Perhaps, Mr Chairman, I might direct my question to the parliamentary assistant and ask where, if at all, the very cogent arguments for geriatric dental programs in longterm care facilities, where those discussions are currently with the government and where the government's planning is within the Ministry of Health in these matters.

Mr Wessenger: I'll ask the ministry staff to indicate if there's any aspect of that involved in this forum.

Mr Quirt: The long-term care facility manual draft requires that, as a standard, oral assessments upon admission by facility medical staff be completed. I know presenters this morning have commented that this may not be the most appropriate practitioner to do that kind of an assessment, and I think that's a very valid perspective. Secondly, it requires that annual dental and denture assessments and preventive dental services be made available to the resident.

Mr Jackson, it doesn't deal with the issue that I think you're raising, which is whether in fact the cost of dental services would continue to be the responsibility of seniors in Ontario. It goes on to say that daily oral care would be identified as a required topic for in-service training, but the long-term care redirection does not propose to provide dental services to seniors on an insured basis. I think that's really the question you're asking.

Mr Jackson: So there are no discussions and no plans at this time to address the dental care needs of institutionalized seniors?

Mr Quirt: Bill 101 and the long-term care division is not proposing to cover all the costs of dental care for seniors in long-term care facilities. I know the minister herself is aware of the recommendations of the Hicks committee and others on the need to look at the issue of the costs associated with dental care for seniors. There are also efforts under way to require public health units to be more involved on a mandatory basis in assessing the dental health of seniors and others. But I'm not aware of any proposal

currently to make dental care an insured service or to provide funding for dental care for seniors. If there is one, I have not been aware of it.

Mr Jackson: Okay. You've answered the question twice two different ways, but I got the same answer, "We're not planning any program currently around the cost aspect of dental care for seniors in long-term care facilities."

Mr Quirt: Not that I am aware of.

Mr Jackson: My next question is, when your government increased user fees and indicated that a greater portion of seniors' limited incomes can be contributed towards their accommodation, what, if any, impact analysis has been done which considers that there are other fee-for-service necessary medical—I'll call them interventions; they are in fact interventions because it's proactive and preventive health care when you're dealing with dental work—to what extent was your government sensitive to those costs when you are taking a bigger bite of it just to put a roof over their heads?

I recognize fully that what's in the legislation currently is simply a statement which says we encourage dental care and our doors will be open so they can come in and under no circumstances can you bar a dentist and a hygienist from coming into a nursing home. That's essentially all that we're offering seniors in these institutions.

I just want to ask what impact analysis has been done about these costs for seniors that flow from their health, according to this report, as well as their mental health? Was that considered when you came up with the increased user fees?

Mr Quirt: There was no analysis or study of the specific costs related to dental care, so the answer to your question is no, there was not a study specific to dental costs.

Mr Jackson: Do you think it would be fair for the minister to begin analysing that, since a senior citizen has certain supports which flow from his or her ability to enjoy life with dignity and dental care happens to be one of them? It may not be as important as getting three meals a day, but it's certainly up there with all their other medical-type interventions.

Gum disease and all the other degenerative aspects of poor dental care only compound this with additional drug costs, with medical interventions, with modified diets. There's a great list of things when one understands this, and I know, Mr Quirt, you wouldn't be working for the Ministry of Health if you didn't already know that.

Mr Wessenger: I think perhaps we're getting into, if I might respond to Mr Jackson, more political issues here as distinct from ministry issues. I don't want to put Mr Quirt in the position of answering policy questions at the political level. Certainly I'm aware of the Hicks report. I've had some discussions with public health unit people concerning the need for dental services for the senior population, and certainly that is something that I can only say is a matter that is being looked at.

The only thing I'd have to say is, we all have to remember the financial realities we all live in politically and financially at the present time. We live in a world with an expanding ability to meet needs and the lack of financial ability to meet all those needs is always a question of priorities. I think that is something that governments always have to make those difficult decisions as to which priorities they establish. Certainly there's a recognition of the needs but there's a question the ability to meet those needs.

Mr Jackson: I certainly appreciate the parliamentary assistant jumping in on any occasion, but that's limited comfort, to state the reality.

I want to just return to the point that at no point in the last decade has it been more relevant to raise these issues. When we're dealing with restructuring long-term care, we are promising our Ontario citizens quality and access and equity. We knew the fiscal realities we're dealing with. I'm just rather disappointed that the financial impact of medically necessary interventions was not considered when the user fees were increased for seniors. I regret that has occurred by this government.

Dr Boccia: I just want to clarify one point, that dentistry has not been barred according to the act. Yes, conducting treatment as well as public health. Public health hasn't been doing it and the problem that the dentist has is that the facilities do not have sufficient administrative support to accommodate a dentist on an ongoing basis, whether it's the actual administrators or the facilities within the home etc. Dentists are making attempts today, all across Ontario, to enter these homes but with great resistance.

The Chair: Thank you. Mr Owens.

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Mr Stephen Owens (Scarborough Centre): I'd like to thank you for your presentation. As usual, you hit a very important nail squarely on the head. It's been my experience through my own dentist, Paul Aquilina, and a dentist who occupies space in the same plaza, Stephen Abrams, that there's a commitment to patients and especially to those who are having income difficulties or to seniors. As a matter of fact, we've nominated Stephen Abrams for the Canada 125 award in our riding.

I don't want to be difficult to the parliamentary assistant but he knows, through working with me on the Advocacy Act, my commitment to these kinds of issues.

I'm looking at page 12 of the draft manual and it talks about the oral and dental care and that, "Arrangements for dental assessment and preventive services, scaling and cleaning annually for residents wanting the service on a fee-for-service basis will be arranged."

My question then is, if a person is not in a position to afford those services—and dental professionals, in my view, in my experience, have been quite reasonable in my riding. I'm not going to speak for dentists across the province, but there is an attempt to operate on a reduced-fee basis. But at some point, somebody's got to pay for something in this process. I'm wondering whether the ministry is prepared to sit down with the Ontario Dental Association and work out some kind of process that would, in my view, be an excellent addition in terms of the quality of life.

Mr Jackson indicated quite correctly that perhaps dental care is not as important as food, or however it was put. But the problem is that if a person has one of the gum diseases or gums simply retract as part of the aging process, food no longer becomes the issue; it's the ability to ingest the food that becomes the issue.

I guess my question to the parliamentary assistant is, what ability is there at this point for the ministry to sit down with the Ontario Dental Association and its practitioners and work out a process where an effective program can be implemented?

Mr Wessenger: I certainly acknowledge your point to the extent that we do have in our society, as you know, dental programs for children and we don't have those same programs for seniors, which is certainly a gap I would acknowledge exists. Certainly I think we should be working towards—I agree with you—working with the dental association.

Mr Owens: My concern about this, quite frankly, is that there appears to be a political war going on between the municipalities and the provincial government on the backs of the poor, the seniors, and at best there is a hodge-podge system with the provision of dental services.

On the Toronto side of Victoria Park Avenue, the city of Toronto provided dental services for welfare recipients, for instance. On the other side of Victoria Park, roughly 50 yards or less in distance, the city of Scarborough did not provide those kinds of services. I think from the approach of the quality of life issues—and I agree with the intent of this bill and the purpose of this bill—if we can't provide it within the context of Bill 101, then in terms of companion legislation, this certainly should be looked at in terms of the provision of these kinds of services.

Mr Wessenger: If I just might make a comment on that, though. Perhaps I'm the wrong parliamentary assistant to be making that comment, but certainly the process of the assumption of social assistance, 100% by the province, should ensure that we have a consistent policy with respect to the matter of, for instance, dental care. My concern is, and I would really need ministry advice on this matter, how seniors fit in in that social assistance scheme.

The Chair: Before we resolve all of those issues, I'm afraid I'm going to have to move on to Ms Sullivan or we're going to be in real-time trouble. Ms Sullivan with the last question.

Mrs Sullivan: I think this is an important brief, because these issues have not been before the committee before this point. I'm interested first of all in knowing if the ODA has been involved in the consultations on the draft manual and has participated in the discussion with respect to the draft manual.

Dr Boccia: No, we have not.

Mrs Sullivan: I think that is one of the problems here. I'm going to have to ask for some clarification here, having just seen certain sections of the draft manual last night. If we look at the existing regulations under the Nursing Homes Act, there is one regulation that says, "Where a resident or a physician attending the resident informs the administrator that he or she is in need of the

services of a dentist, the administrator shall arrange for the resident to receive that." That's what happens now.

If we look at the draft manuals, the first draft is far more extensive than the second draft. The question is, does the second draft incorporate everything from the first draft or is the second draft going to be what the final form is?

Mr Wessenger: I will ask ministry staff, though I can assure you the second draft is still a draft.

Mr Quirt: I'm quite frankly not aware of the differences between what is said about dental services in the first draft and what's said about them in the second draft. There may well have been an omission. Because I'm not aware of what was in the first and second—I haven't looked at it recently—I can't answer your question. If there's a recommendation you have on what might be returned to it, we'd be happy to discuss that with our manual committee when we revisit the manual on March 15.

Mrs Sullivan: What I'm seeing is a difference in that the first draft includes standards, administrative criteria, staffing criteria and service provision criteria. The second draft appears only to cover standards, and I think it's significant that the dentists haven't even been consulted on it.

Mr Quirt: It appears to me there might be something missing if there's that big a difference between the first draft and the second draft. We'd be happy to have a look at it, talk to staff to find out what the intent was in any change and on whose advice it was made, and reply to you specifically on that if you'd like.

Mrs Sullivan: Perhaps we can have a clarification, but—

The Chair: Mrs Sullivan, I'm sorry.

Mrs Sullivan: Am I out of time already?

The Chair: We're in big trouble with time. Could you just put one more question, because I want to allow the witnesses to comment.

Mrs Sullivan: I think it is interesting that there appears to be an improvement in the manual in that, at least in the standard of care, there would at least be an annual oral assessment, including scaling and cleaning. However, that would be done on a fee-for-service basis. I'm interested in your mobile dental units and how you see those services being provided through those dental units. I'm interested in the insurance question as well, but we don't have time to get into that.

Dr Boccia: First of all, we were a little disappointed that we weren't consulted and we are certainly prepared to do so from today on. At any time the ministry would require our assistance, we will be there. We are disappointed that the public health people have not done their job; I am personally. From 1984, they've been complaining of funding and manpower as well and haven't entered many of the homes even within the Toronto boundaries, never mind the rest of Ontario.

With respect to the mobile equipment, Toronto right now has a full dental unit which is being shared by the four component societies, and that's basically a north, south, east and west division of Metro Toronto. We have been working with public health people who will go in and screen the patients initially, because unfortunately, there is a cost for screening as well, consultation, the reporting back to the family etc.

Public health has been handling the situation by simply identifying the patient in need. There is no real screening. no real dental treatment plan or assessment done. They just have a quick look, do some prophylactic care if they can. and then report back to a central body, which I'm involved with, which identifies the patient. We then send the unit into the home, do the initial screening and report back to the administrator, who in turn goes to the family member. if there's a family involved. Then discussions go back and forth, literature etc, with dentists and the family sometimes, to come down with a final treatment plan and costs. and then the dentist is allowed to administer the treatment. The dentists bring in their own assistants, their own materials etc. The unit has been made available through the Academy of Dentistry here in Toronto at a cost of just under \$25,000

The Chair: I know we could go on for some time, but I think, as you can see among all the members who are asking you questions, your points have been heard.

Dr Boccia: Thank you very much.

The Chair: Thank you very much for coming.

1110

COPERNICUS LODGE

The Chair: Perhaps I could then call upon the representative from Copernicus Lodge and just note to committee members, with some chastisement of the Chair himself, that we do have a time problem. If members could just ask one question, it would assist us in getting through the rest of the schedule.

Welcome to the committee this morning. If you would be good enough to introduce yourself, then please go ahead with your presentation.

Mr Stan Mamak: I am Stan Mamak, Copernicus Lodge. Apart from a bit of raw cold today, it's another gorgeous day to be thankful for. I'd say the average person in this room, each one of us, has approximately 4,000 to 5,000 more such days before we begin a descent. Let me read you two descriptions of that descent:

"We do not die wholly at our deaths; we have mouldered away gradually long before. Faculty after faculty, interest after interest, attachment after attachment disappear. We are torn from ourselves while living.

"Growing old is not a gradual decline, but a series of drops, full of sorrow, from one ledge to another below it."

Copernicus Lodge is a non-profit home for the aged under the Charitable Institutions Act. I've been a volunteer there for in excess of 13 years, a member of the executive committee and have headed numerous committees. We are greatly concerned that Bill 101, as it stands now, certainly appears to focus on physical health care needs. What about the other half? What makes life more than just surviving, where a stranger has the potential of being an unmet friend? We have the means to express one's faith, familiar food tastes and smells and a reassuring warmth of long-lived cultural traditions and expressions.

What, to each one of you, do the following words mean: golombki, oplatek, wielkanoc, sto lat, przyjaciel? To seniors among our community, they're laden with emotional resonance. If you're a parent or a grandparent who comes from a proud cultural tradition that has included Copernicus, Chopin, Lech Walesa and Pope John Paul II and you're suddenly designated to be put in a given place by a "placement coordination service" or a placement coordinator, with scant, if any, regard, in our reading of this legislation, for your language, your culture, your psychogeriatric status in terms of fit with other people who are going to be in the home in which you're placed, what does that mean to you?

For many of our parents and grandparents, the descent into old age is probably one of the most terrifying experiences in their lives. This is no time to further traumatize them by placing them in an insensitive environment.

I've attached two letters from families of residents who have stayed with us at Copernicus Lodge to indicate to you the kind of atmosphere provided there and to point out that this was achieved. We have the lowest per diem cost among care institutions of this type in the province.

I've received a report from a seminar held in Burlington on February 10 of this year, Ethical Challenges of Health Care for the Elderly, in which an M. McLean, who is a professor of gerontology at McMaster University, spoke about the rights of ethnic or multicultural people to die in their own community. He referred to the case of a French-speaking woman who died while in the care of an English-speaking doctor and nurse. The woman's daughter was very distraught knowing her mother's final words were not heard or understood due to the language barrier.

A court challenge ensued and the court ruled that individuals have a right to die in an environment familiar to them. Mr McLean feels that the individuals not only have a right to die in their own environment, but they also have a right to live in their own environment. We share that belief.

I'd just like to pose some questions to the committee. Why in Bill 101 are you ignoring the accumulated experience and wisdom of countless groups in Ontario with hands-on experience in long-term care of our parents and grandparents in favour of a theoretical construct or series of constructs? In my view, it is somewhat like saying: "Well, we want to build a new house. Forget about the experience of engineers and architects; we've got a great theory here."

I think we all remember the great intellectual fads. We had the Hall-Dennis report and open-concept schooling. Where has that gone? Into the trash bin of history. Here we're talking about a new intellectual fad, in our view: one-stop shopping. In my view, we're talking one-stop disaster.

I challenge any member of this committee to point out where in Bill 101 as it stands provision is made for religious, cultural or psychogeriatric sensitivity in the placement of our parents, our grandparents and, in the near future, ourselves. Why is the proposed system throwing out things that are working well? In other words, don't fix a sound wheel. We have homes, we believe, that work well and I believe that a home such as ours is imbued with respect for

the individual, with a degree of caring and contentment and, ves, love.

Why in the legislation as it's written now on second reading is there virtually no mention in regard to linguistic, religious and cultural factors? We believe that not only the application materials but the legislation itself must be amended to reflect these critical components. These are not frivolous extras.

Why is there no possible appeal, as I understand it, of a placement coordinator's decision to place the person? As I understand the legislation, there is an appeal in regard to whether you're eligible for long-term care, but unless I have missed something in the legislation, I'm not aware of any appeal as of right to an individual in regard to the placement that is made of that individual. Think of it: Suddenly, somebody tells you where you're likely to spend a good portion of the rest of your life, if not the rest of your life, and you have no chance to appeal that decision.

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Why are the contributions and the commitment of community groups and volunteers effectively being ignored and neglected by this bill? Why are they in effect being told to get lost? In sum, when virtually all of the groups in the province that have been involved in long-term care of multicultural elderly agree that this bill will jeopardize services for thousands of seniors of multicultural background, why is this bill being proceeded with in this form?

Let me put it to you a different way. This bill would be wonderful legislation as it stands if (1) you wanted to commit psychological violence to our seniors by placing them in an alien and insensitive environment in many instances; (2) if you wanted to warehouse parents and grandparents according to relative degrees of physical infirmity; (3) if you wanted to take the caring out of long-term care; (4) if you wanted to create even more obstacles to access to long-term care for multicultural parents and grandparents; and (5) if you want to guillotine existing community involvement and financial contribution.

I've included a quotation at the end of the very brief brief there, a paraphrase of a German proverb, "An old person loved is winter with flowers." As it stands, in our experienced opinion this bill will not facilitate winter with flowers for our parents, grandparents and, in a not-so-distant future, ourselves. We believe it's a papier mâché of the real thing. We urge an uncommon exercise of your judgement, wisdom and compassion, for in the end the bell tolls for each of us as we age.

The Chair: Thank you very much, both for your oral presentation and for the brief that you've submitted and, I just note for Hansard, along with some letters you've attached. We'll begin the questions with Mr Wessenger.

Mr Wessenger: Thank you for your presentation. I'd just like to make clear to you that it's never been the intention to not be sensitive to cultural, linguistic and religious aspects. It's also, perhaps because of a misunderstanding, been that legally people have to consent to where they're placed. What we have done and announced yesterday, in order to clarify the situation, is that we would be bringing an amendment which would require the placement coordinator to take

into account the preferences of the applicant, particularly with reference to the aspects of cultural, ethnic, linguistic and religious matters.

That's going to be an amendment in the legislation to make clear, because there was never any intention not to take any of this into account. In order to clarify the uncertainties that evidently have been created out there, that amendment will be placed. It will also be made clear in the legislation that the individual must consent to his placement. That was a legal right there, but we're putting it in there just to clarify, and also the right of the institution to refuse where it doesn't have the physical facilities or the trained staff appropriate for the placement.

Also, I might just refer to your other aspect. You did raise the question in your written brief with respect to placement coordination services. There's certainly no intention to have only placement coordinating services, particularly in the Metropolitan area, in English only. Obviously, in order to work in that type of culture and the linguistic situation we have to have those services available in other languages.

Mr Mamak: Are you giving a commitment that you will have them available?

Mr Wessenger: I think it's fair to say that we can certainly give a commitment in the Metropolitan area. Whether you can provide it, I don't know. I might ask Mr Quirt to comment on how we provide it outside the areas where you have a diversity.

Mr Quirt: Certainly the placement coordination services would be available in both languages in those designated areas across the province where the service would be available in French as well as in English. In Metro Toronto, there would need to be a number of different capacities to speak the language of a number of different potential candidates for our long-term care facilities.

That would be a requirement the government would make of the agency that was selected to be the placement coordination agency, that it had the capacity to respond to the needs of the residents of the area effectively in whatever language necessary. There may well be arrangements where a member of your staff or a member of the staff of other charitable homes for the aged would be called upon on a contractual basis or something to assist the placement coordination agency in that way.

Mrs Yvonne O'Neill (Ottawa-Rideau): Thank you, Mr Mamak. I think you presented your points—others have presented them truly, but you presented them with a great deal of poignance and reality. I can see why you are having so much difficulty because, as you can see, your question has been ours: Is that a commitment?

Each time someone like yourself comes forward, we are told that there are amendments and it has actually been read into the record, although we haven't seen it in writing. We see the service manual changing some as it's progressing now at draft 2. We know there are a lot of regulations that are going to come, but all of this is being done with a great deal of request for a leap of faith, and I'm not sure that we have enough to go on, even after six weeks of

hearings, or that we feel your concerns are going to be addressed the way we hope they will be.

The appeal process is where I'd like to place my question. We have had lots of discussion about that. Could you put a little bit more into your fears about the appeal process from your perspective?

Mr Mamak: Are you talking about the appeal process in terms of whether you are eligible for long-term care?

Mrs O'Neill: No. the second part of your statement.

Mr Mamak: In terms of the placement, I mean, I'm not completely reassured by the comment that you can refuse a placement. That potentially could be empty if the person says, "Well, sure, you're entitled to refuse a placement, but if you do, sayonara."

Mrs O'Neill: This is a general fear, you know, about how long and what kind of personal preference guarantees do we have in this legislation? At the moment, we don't feel they're there.

Mr Mamak: I concur with that. I feel not only that they're not there but the legislation embodies the values, and if you don't have those values but talk about putting them in regulations, talk about putting them in manuals, they can be manipulated so easily, they can be omitted so easily and without public notice, without public discussion. We want them in the legislation, period.

Mrs O'Neill: Which is your only guarantee in the courts.

Mr Mamak: Exactly.

The Chair: I'm sorry. We have to move on. Mr Jackson.

Mr Jackson: I wanted to thank you for your references to eastern European culture generally as well. My grandmother has the privilege in the province of Manitoba to reside in a facility similar to Copernicus Lodge, and I simply wish to thank you for committing these concerns to paper and in the presentation on an ongoing basis. I think that's important. Even though we've had the assurances from the parliamentary assistant, it's abundantly clear that it does not guarantee the ethnicity of a certain facility; it only indicates that it'll be considered.

I also want to thank you for your old German proverb, which I think is quite beautiful.

The Chair: Thank you very much, Mr Mamak, for coming before the committee today and making your presentation.

1130

AIDS ACTION NOW

The Chair: If I could next ask for the representative from AIDS Action Now, welcome to the committee. If you could just introduce yourself, then please go ahead.

Ms Patti Bregman: I'm Patti Bregman and, just to make the record clear, because I was here a couple of weeks ago on behalf of another group, I'm here as a volunteer with AIDS Action Now. I sit on their provincial issues committee. Part of my interest in AIDS Action Now is because of the long history it has had in working within the community to create and develop community-based services and programs.

Unfortunately I got snowed in in Peterborough yesterday, so we don't have a written brief for you this morning, but basically AIDS Action Now is a participant in the coalition on the long-term care and disability issues. However, there are specific issues which are significant to the AIDS-HIV community that have not been addressed in long-term care.

AIDS Action Now has been very active, as I'm sure most of you know, within the government and outside the government, sitting on committees like the Ontario committee for AIDS and HIV. Long-term care unfortunately did not deal with these issues, and I think the context we're placing it in is that we're seeing a rapidly increasing number of treatments. We're unfortunately also seeing a rapidly increasing number of cases diagnosed, with the most rapid growth being outside of Metro Toronto, and that is part of the issue we need to address. We're also seeing a more educated group of people coming up and learning more. We're seeing doctors who've learned to work with clients.

Unfortunately, what we're not seeing is the corresponding growth in the kinds of home care and support services that are going to be needed to ensure that people who are HIV-positive or have AIDS can really live in the community and participate, pay taxes and continue working as long as possible. To some extent what we see is that unless the government addresses the issues of long-term care and community-based services for people with HIV and AIDS now, we will see a major crise in terms of the cost this will bring. We'll have more and more people in acute care hospitals as opposed to being able to live in the community.

We have another problem, which I think can't be addressed by this committee but has to be recognized in looking at the specific issues of HIV and AIDS, and that is the limited expertise of professionals. We need to look at making sure both more professionals become educated and more supports are provided, but I think in terms of regional funding issues, we have to recognize that many people will gravitate to larger centres, because that's where the treatment is.

We do have a concern that if we're on a regionally funded base system, areas like Metro Toronto or London or Ottawa, where we'll see the cases going, are going to lose out, and we'll have some problems in allocating funding. People from rural areas will be moving into the city. We need to make sure that whatever funding allocation system is set up accounts for the kind of movement that will occur until we can get the specialized services and housing and other supports into the community.

The first recommendation we want to make, I think, is that the provincial government make a clear commitment that the needs and interests of people living with AIDS and HIV will be integrated into the ongoing reform of long-term care. People with HIV and AIDS must be included in the process of developing these services.

As I said, we have a very long history of working quite effectively, and I think right now, as a result of pressure from AIDS Action Now, the Wellesley Hospital is developing a standards-of-care manual for physicians and health care professionals treating people with HIV and AIDS. This

is being done as part of a joint community-professional endeavour, and that's the type of involvement we see.

It's not simply sitting on a committee. There needs to be input and control on an ongoing basis, and I think the community has demonstrated the expertise and the willingness to put resources in. AIDS Action Now does not get government funding. It does not have paid staff. These are people who really care about what's happening and have a very strong commitment. So we need to see that type of commitment from the government.

I think in terms of the barriers that we see, there are two. One is the lack of services. The other is waiting lists. As people are living longer and can use more and more community-based settings, things like supportive housing, waiting lists become a major barrier. People don't have time. While it's long-term care in the sense that people with disabilities have it, it's long-term care that has to be delivered immediately, and the consequences, we know, of not delivering appropriate care immediately mean death comes quicker or you lose your capacity much faster. We don't have time to deal with waiting lists and we're going to have to look at ways of either allocating specific services or waiting lists or somehow recognizing the urgency of the situation and making sure resources are going there.

The other area we wanted to address in terms of home care is that while there are some home care agencies that have done quite a good job and are providing IVservices in the home, there need to be an increased number of services available, but we also need to get rid of the dividing line between medical and social services. I think you've heard about this from the other disability groups.

What happens is you get caught between programs. One program will provide a little piece of this, another program provides another piece and another program provides a third piece. If those programs either have eligibility criteria that exclude you from one and to live in the community you need all three or you're not funded to receive all three, it's not going to help. You won't be able to stay in the community.

I think one area in which this is clearly evident, and I think you've seen comments about it recently, is in drug funding. While drug funding is not part of long-term care, if people don't have access to drugs or access to nurses who can do IV therapy at home, they are forced into the hospital, and it won't matter what other services are being provided. So we need to see a breaking down of the barriers between the different kinds of services so that we don't create gaps that people will fall through and then not have access to services.

I think one of our recommendations is that you start to look at funding, a pilot program working with the AIDS-HIV community and with the existing service providers to see what we can come up with along the lines of the integrated homemaker program in East York. Let's not only look at developing pilot programs that use existing service agency supports but let's look at how we can involve the existing volunteer supports, of which there are many in that community, and integrate them. We're not talking about putting in large amounts of money. What we're trying to do is to take a look at the system and find more

effective ways to use money that's in the system. There may be small amounts needed, but we're not suggesting the government should suddenly place huge amounts of money into home care.

What we want to see are pilot projects working with the community that guarantee the long-term funding it needs to sustain service agencies that will put some time into it, but to really use what's in the community.

One particular gap that's been growing as the number of women who are infected grows is the need for supports for mothers, which is not simply respite care but respite care where creches are provided or day care is provided for children. Women's needs have generally not been addressed in the area of AIDS and HIV, and there's a growing concern about that.

But I think it's particularly important in the area of community-based services, community care, home care going in or even supported housing that we recognize there are going to be single mothers who are HIV positive who may live eight to 10 years who should not be deprived of the right to live with their children simply because they have an infection. We need to make sure that we're providing that type of respite service and counselling available for the families all the way along.

There will be, similarly, mothers with children who are HIV positive. They need services, but it's a different type of service. We're very concerned about the growing number of single mothers who are HIV positive and who have very few family supports. We're not dealing with a population where the grandparents say, "Come home and live with us." We're dealing with a population that has, as a rule, very strong community supports. There are people in the community who will help, but we don't see it in terms of the service providers. They are there.

In terms of Bill 101, and I think this is where our interests converge, it is to make sure that direct funding can also be used for this type of service; in other words, not simply attendant care services but to make direct funding available to help people who are living in the community who may be falling through cracks or may need additional services so they don't have to give up jobs.

One of the real concerns right now in the community is that people are being forced to stop working and go on welfare in order to receive certain benefits. I think everybody would like that to stop. People would like to be able to keep working. So we need to look at direct funding as that type of subsidy that could be available for very specific kinds of cases.

The second area which I think we need to address a bit is the area of supported housing and accommodation, because again we run into the problem, and it's really a double discrimination where people with HIV are discriminated against. We know that there are people who are uncomfortable. You go into a nursing home and they say, "We can't deal with that kind of client." We have hospitals that say, "We can't deal with that." That can't last.

Firstly, we need good community housing. In other words, we need housing in which people can remain even if they need a certain level, and one of our suggestions is that we look into using existing housing. Look at the hous-

ing where people live. In many cases, you'll have communities already established. You'll have a number of people who are HIV positive living within a geographic area. Let's look at how we can work with the community to use that housing and provide outreach services into that housing. Rather than dislocating people from existing supports, let's look at bringing the supports in, and I think that's something that could easily be done in Metro Toronto as part of a pilot project.

What we'd like to recommend is that we fund these projects and that they're based on existing consumer-initiated projects and coordinated models with the community. We don't want to go out and develop new models. We're not looking, as I said, for huge amounts of money, but let's start looking at funding projects that keep people in their homes. Even if they need additional levels, let's bring the service in. Let's set up small supported living units within existing housing rather than trying to go out and build new housing or dislocate people.

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We need to deal with the next level of housing. There is almost nothing in the province, with the exception of places like Casey House, which is hospice and palliative care. We need to look at some of the innovative programs that are developed, for example, in England that will provide the next level where people really can't live independently. This is going to become an increasing problem because of HIV dementia; and it's become more and more recognized that as people live longer with AIDS and HIV we'll see more and more cases of dementia.

We have a great deal of concern about what's happening now. ARCH has already received calls about two cases in which people were committed to psychiatric facilities, not because they had a mental illness that could be dealt with but because they were outside of Metro and they said there was nowhere else for them to go. Families say, "They can live with us." Nursing homes won't take them, retirement homes won't take them, so let's put them in a mental institution.

Unfortunately, the boards of review said, "Yes, we agree there's no other option." So I think we really need to start addressing this, and it will have to be addressed creatively, and, I think, depending on the location, with different kinds of options. In some communities, it may be possible to take a floor in an existing facility and set up some special services that are available.

I think part of it is educating the public. Once people understand that you can put people with HIV in settings with everybody else, a lot of that fear will dissipate. We're doing it in public hospitals, but we have to recognize that there are going to be specific services that are quite unique. We are not suggesting that you set up around the province different types of housing specifically for AIDS and HIV people, but I do think we need to look at this and we need to look at it in the context of Bill 101 and make sure that there's no discrimination permitted against people who are HIV positive and that one of the requirements is that the facilities are really going to have to acknowledge that they are going to have take people who are HIV positive

unless the government's prepared to come up with some other alternative.

So I think essentially, as I know you're pressed for time and there may be questions, that really what we're trying to say is that we understand fiscal limitations, we understand sexual limitations, what we haven't vet seen is anybody addressing the specific problems of the AIDS-HIV community. We think it's a community that's shown a phenomenal amount of strength in developing some really innovative programs. In some respects things like the senior day care programs are replicated in the HIV community. I think it would be really beneficial to specifically focus some of the reform on this and also use it as a learning experience. I think we can look at the programs that have been developed, and it's one of the areas in which I think consumers have truly developed a partnership with professionals. What we see are doctors who have responded to people with HIV learning more. They set standards. They work with the doctors. They work with the community. People go in and advocate. We need to look at that and learn for the rest of long-term care reform.

But I guess our final message is to really make sure that we're addressing it directly, that sufficient funding is allocated and we don't fall through the holes again.

The Chair: Thank you very much. I don't think the snowstorm in Peterborough affected at all the presentation, and we really appreciate your coming in. Of course, as you know, that is in Hansard, so we've got it. In going to questions—and I agreed to do this, but we do have a time constraint—if members could focus their questions and keep them brief, and we'll begin with Ms Fawcett.

Mrs Joan M. Fawcett (Northumberland): Thank you for coming, because I think this is a topic that we haven't heard that much about and yet we are going to. There is going to be a crisis out there, and it is a different kind of care. These people are young, for the most part, and that presents a problem in its own. The time is so short and there are many questions, but you have certainly given us a tremendous amount of your knowledge.

Ms Bergman: As I said, we'll be glad to come talk to people individually on an ongoing basis.

Mrs Fawcett: That's good. Maybe I would address the parliamentary assistant and ask: Is there contemplation by this government of putting the palliative care under the long-term care bill, 101? Do you feel there is a place for it? Is it going to be incorporated?

Mr Wessenger: Certainly, it's very much a part of the whole process, the palliative care. But I will ask perhaps ministry staff to just indicate what specifically, briefly, with respect to the AIDS-related—

Mrs Fawcett: Maybe if there's anything there now, and if there is contemplation of something further.

Mr Quirt: With respect to palliative care, there will be funding made available to train about 1,000 community service workers in palliative care. There will be funding to train physicians specifically in palliative care. There will be support for about 30 to 35 volunteer palliative care programs across the province in need of support. There will be the development of 14 regional pain and symptom

control teams that will no doubt improve the delivery of palliative care for all clients, including those living with HIV and AIDS.

With respect to long-term care redirection, I know some planning has gone on in Metropolitan Toronto and elsewhere about how supportive housing programs, for example, might be developed for those people needing a structured environment, a supervised environment, particularly for those people who are suffering from a degree of dementia as a result of HIV and AIDS. The changes to the in-home services program will allow us to do a better job of supporting clients with AIDS as well. More of that discussion needs to happen and more planning needs to happen locally at the district health council level to make sure that this population's needs are considered in the overall long-term care planning.

Mrs Fawcett: Hopefully, you'll get a pilot project.

Ms Bregman: Can I just make one quick comment on that?

The Chair: Yes.

Ms Bregman: This is our concern with regional planning, however: In many communities, people are still unwilling to identify themselves as being HIV positive. We're very concerned that if you leave it solely to DHCs and there is no policy coming from the ministry, we will not be seeing the development of sufficient programs around the province. So I really urge you to go beyond just leaving it in the hands of the DHCs, because that will not serve the rest of the province.

Mr Owens: I'd like to thank you, Ms Bregman, on behalf of your group, for an excellent presentation. I think that you make a good point in terms of long-term care having different contexts for different people, and you've provided another context for us to take a look at today.

I think that I'd like to meet with you to discuss some of the issues, especially your supported housing issues. I'm currently conducting a task force with respect to the use of cooperatives. In terms of looking at community-directed services and client-directed services, I think that you may have an excellent fit.

You're absolutely right: In my experience with the AIDS Committee of Toronto in a previous life as a volunteer, the community has clearly pulled together and has driven the agenda, in my view, quite successfully on behalf of the client group contained within the community.

I like your suggestions around the standardization of programs and access points. There's nothing more disheartening than to find out that you qualified for one and a half points in one funding program only to be disqualified in another.

In terms of the issue with respect to women again, the alarming rise in the incidence of HIV infection among women is not yet addressed. I think that it further perpetuates the discrimination that women currently face within all aspects of society, and this yet another issue that needs to be dealt with in terms of how we support the equal partners within the society. So I'd like to meet with you to discuss these issues.

Ms Bregman: Sure. In fact, if I can, I'll meet with you wearing both hats, because I'm working on the supportive housing issue for the disabled community as well. I wear a lot of hats.

The Chair: I have a feeling that you may find, as a result of this, that whatever hat is on, there will be a number of meetings. I am sorry, but I think you can appreciate that you've raised a good number of issues, and clearly ones that have to be addressed, and that a number of people will be following up where more time would be available. So thank you again very much for joining us today.

Ms Bregman: You're welcome.

LEISUREWORLD INC

The Chair: Could I then call on the representatives from Leisureworld. Would they be good enough to come forward. Gentlemen, thank you. I know you've been sitting there for a while and I apologize for running a bit late, but we welcome you to the committee. Would you be good enough to introduce yourselves and then please go ahead with your presentation. We have a copy of your submission.

Mr Herman Grad: Herman Grad, Leisureworld.

Mr David Cutler: David Cutler. I'll be doing this part of the presentation. I'm the vice-president of Leisureworld operations, a chain of nursing homes.

Leisureworld finds itself in a unique position in that we operate under the definition of a for-profit home. In reality, today all our homes are non-profit due to the lack of appropriate funding in the past and now in the future by the delays we're encountering in the passage of this bill.

We believe the seniors of Ontario deserve more consistency in standards and funding of care delivery. We support and applaud the efforts of this committee to facilitate the implementation of long-term care reform and we encourage you to move forward with this bill.

I realize time is limited, so I'll give you a synopsis of our written submission and will then address any questions you might have.

While there are many sections in the proposed legislation that are positive, our concerns pertain to the wording of portions of Bill 101 and certain omissions.

First, there are many unanswered questions raised by the way the bill is written. We are concerned about a wide range of problems that could be created by the approach taken. While we see an intention to be more equitable, some amendments continue to discriminate against residents of nursing homes. We recommend that the government be held accountable to maintain equitable and consistent services in all long-term care facilities throughout Ontario.

We're apprehensive about the movement away from extended care to a contractual agreement model. It disturbs us that there will no longer be a universal, accessible approach to health care in these facilities as the extended care program will no longer be an insured service under OHIP in Ontario.

There's no specific language outlining the content of what a service agreement will entail. In fact, to date, not

even a draft of what a service agreement might contain is available for any of us to review. Equally unsettling is that again there's no accountability placed on the government to provide funds to meet the service agreement.

The development of the case mix index, which scores one facility's care level relative to another, by no means guarantees that funding will be sufficient to ensure the assessed needs of the residents are met. The bill holds facilities accountable for providing all residents' needs without ensuring that funding will be provided to make this possible.

Next, the legislation states that the care outlined in a resident's care plan must be provided. The problem is, there's no flexibility should the resources not be available to provide the services outlined in the care plan. In fact, this legislation may seriously discourage accurate and detailed plans of care due to lack of resources stemming from lack of funding. To make matters worse, because there's not enough money in the system to meet all residents' assessed needs—that's what this whole study was about—as identified in the care plans, facilities will automatically be in breach of their contracts.

We recommend that the legislation not require facilities to provide all services as defined in the care plan unless the government assumes the responsibility of funding these services.

There are no details of how the placement coordinator will function. I heard earlier the parliamentary assistant's comments on the amendments to be made. We suggest that the duties be outlined in the legislation and that this position be given the responsibility to determine eligibility for placement, to identify a substitute decision-maker for the applicant, to determine the applicant's ability to make the copayment, to identify a responsible party in the event that there's default of the applicant's payment, to take consideration of the applicant's choice with respect to ethnic, linguistic, geographic and religious preferences, for discharge planning and coordination involvement when a resident needs to be moved to another location and, further, to provide services seven days a week, 24 hours a day, because these residents might require movement on weekends at all hours.

We would also suggest that existing resources be used for their function and that no new level of bureaucracy be created for this purpose.

Eligibility determination should be a combination of physical, medical and social requirements. Facilities must have the right to define their missions and the type of services they are able to deliver. Both applicants and facilities must be able to refuse a placement based on the client's preference and the home's ability to meet the resident care needs.

Both applicants and facilities must have a timely and efficient appeals mechanism with respect to placement.

The immunity clause that protects placement coordinators and inspectors, as now determined to be used, for acts done in good faith must be expanded to include facility staff as well.

With regard to the sanctions, we wonder if the bill is not creating a potential nightmare for a resident and his family. In many cases, sanctions such as freezing admissions and withholding payments will in fact jeopardize the provision of care to residents still in the facility. Sanctions should only be implemented as a final resort and facilities must have the right to appeal the sanctions implemented.

We are extremely disappointed to see the reintroduction of the word "inspector." Past experience has shown that the inspector model created an adversarial climate that was not in the best interests of quality care. It failed dismally. All long-term care facilities, regardless of their profit designation, must be reviewed under the same set of standards and criteria.

We strongly support the continuation of the current compliance management program which stresses consultation rather than confrontation.

We question why the powers of the inspectors need to be increased. The recently passed Bill 74, the Advocacy Act, negates this need, as advocates will help to communicate and assist residents with unresolved issues and problems. That is the purpose of Bill 74. Let it do its job.

While we support the concept of quality assurance programs, the term itself is outdated. In the past two to three years, for instance, our company has grown from a basic quality assurance program to a more refined total quality management program. We suggest a more generic term such as "quality management" be used.

In addition, we do not support inspectors being given powers that allow them to review and possibly use our total quality management information for their own purposes. I respectfully submit that allowance of this will cause a facility to develop an ambiguous approach to self-evaluation and the whole philosophy of total quality management will become meaningless. Very seldom does government legislation encourage growth, also, for us to monitor our quality of service without bureaucratic intervention.

Consistent with the above concern is our aversion to the inspectors having any rights to personnel records, peer reviews or performance reviews. This can only be seen as a total invasion of staff privacy and serves to meet no rational goal. We wonder what confidentiality issues would be breached.

The bill has given far too much power to the government and inspectors without the corresponding accountability. Consumers and facilities, however, have been given very little power, protection or choice. The bill leaves too many issues to be defined by regulations. We haven't even seen the regulations as yet.

We are grateful for the opportunity to address you, but we are really only addressing you on the bill we have seen. We don't know what the regulations say, so how can we do a complete presentation?

In summary, I'd like to stress that this bill should provide reasonable and equitable guidelines for all long-term care facilities. Don't reintroduce policing by inspectors. Keep the consultative approach using the compliance management program.

There are many talented and dedicated people in both the for-profit and not-for-profit sectors. Bring them together under one act that addresses everyone by the same standards, criteria and funding model. 1200

The Chair: Thank you very much for the presentation you've made orally and also the document you have given me. I just note for the record that you have summarized it and that there are more arguments made in your paper. I appreciate the way you did that. Also, I just want to indicate that a lot of these points have been made by your colleagues as well, so I think what you have done is support some of those particular positions. We'll begin the questioning with Mr Wilson.

Mr Jim Wilson (Simcoe West): Thank you for your presentation. I think it was concise and to the point. As the Chair said, a number of the points have been raised, but our experience with these committees is that repetition is a good thing to drive the point home; for instance, the very fact that there's no obligation for the government to actually live up to its part of a service agreement or to actually fund you so that you can fulfil the plans of care, and many other points with regard to inspection, the placement coordination system and the powers of placement coordinators.

These points have been made for weeks now and the government just hasn't come forward with its amendments at all yet. You'll get lipservice from the parliamentary assistant and from members opposite indicating that they're quite willing to, in some areas, make some changes. We've not seen those.

You did mention a point, though, that I did not ask before, and that is that you recommend that the placement coordinators should identify the substitute decision-maker and the person if it's not the same person responsible for financial obligations of one of your residents. What happens now when a resident goes into default of payment? Do you take a normal small business approach to that or do you just sort of carry on?

Mr Cutler: Invariably, it involves us in having to write off the money, even if there is a contract signed by a substitute. We try to collect the money, but you just can't draw blood from a stone, so to speak. It's very difficult.

Mr Grad: In 20 years we have never litigated with a resident and we're not prepared to do that. In many cases, relatives simply won't pay and we just have to write the money off.

Mr Jim Wilson: That's interesting. It's useful to hear how you handle that, because I think the impression left out there of nursing home operators by some people in the communities is a picture of you people as the big bad wolves who don't treat your residents fairly and that sort of thing. But in terms of default of payment, you take a very humane approach to it and a commonsense approach. It would be helpful, though, I gather, if the application form clearly spelled out someone else who might have that obligation on behalf of the resident.

With regard to access to records, your points made in that section of your brief, I'm having déjà vu all over again, as I'm sure members of the Liberal Party are. We went through this with the Advocacy Act. The government has back in this legislation all the stuff we tried to take out of the Advocacy Act. We were somewhat successful in

ensuring that some of these internal management tools were not used inappropriately against institutions.

Do you want to just take a minute to explain to the committee the importance? I think you very honestly said to the committee that if inspectors have access to quality review activities, peer review, performance review activities or quality improvement activities, the records pertaining to those activities, it could very well force you to write in code or have a not-as-effective quality management system in place as you should.

Mr Grad: We have a contradiction at the moment in that our union agreements—we deal with several unions—don't allow us to provide those confidential records to anyone and yet the government inspectors would be able to come in and look at private and confidential personnel records. It would create many problems for us if that were to continue.

Mr Jim Wilson: Has that been discussed with your unions? Are they aware of this?

Mr Grad: Unions are not prepared to discuss too many things these days and they're not prepared to back off any agreement or give in in any way, specifically with respect to this issue.

The Chair: Mr Wilson, I'm afraid we're going to have to move on. Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. I think I have met with you on previous occasions and am certainly aware of your facilities and your concerns

First of all, I'd just like to just make some clarifications. You've mentioned the insurance model, and I'd just like to suggest to you that, first of all, the insurance model of course is not a requirement under the Canada Health Act for this type of care. Secondly, the homes for the aged have operated on a non-insurance model and seem to have done quite well under that system. Thirdly, I think certainly by moving to a contract model it provides the flexibility of allowing the provision of open beds for respite care and emergency care which I think does have an added advantage to the system.

With respect to some of your comments, I think I can provide some clarification. First of all, on the question of the compliance system, I'd just like to assure you that this system will continue in effect. Second, with respect to your comments concerning quality improvement programs, the only thing I can do is to assure you that we're looking very carefully at that with respect to the information question. With respect to generic terms, I think we certainly agree with you in principle. We'd prefer to have generic language rather than buzzword language with respect to the question of quality programs.

With that, I'd just like to thank you for your presentation. We certainly hope that we all see this legislation in effect quickly.

Mrs Sullivan: Once again, I appreciate this brief. We will have amendments that respond to many of the issues you have raised that we'll be putting on the table.

I want to clarify, because this has come before us again this morning from the ministry and the parliamentary assistant, the issue of how there will in fact be continuing equivalency between the commercial homes and the homes for the aged which are not commercial. We certainly understand that where there are voluntary services and fund-raising activities and so on, there can be enhancements in the quality-of-life areas, and that will be more likely in the non-profit homes.

The second issue is the pay equity issue, which is a very serious one in terms of levels of staff compensation. I want to ask the parliamentary assistant if the government is reconsidering its position, given that the principle of this bill is level-of-care funding with respect to pay equity funding for the private sector.

The other question I want to ask the parliamentary assistant is, there has been a clear promise of open beds for respite and emergency care, when in fact there are waiting lists in virtually every community across Ontario. Where are those open beds going to come from?

The Chair: The parliamentary assistant with those two questions, and then I'm afraid we're going to have to move on.

Mr Wessenger: I think, first, the pay equity question is still a matter up for discussion and consideration. There has been no policy established on that as of yet.

With respect to the matter of the respite beds, I'll ask ministry staff to comment.

Mr Quirt: You're quite right that if beds are left open for respite purposes, then a permanent resident is not going to be living in that bed. We feel, however, that by providing respite services in facilities, that bed used to allow family care givers to have a break by admitting their family member for either an emergency situation or for a planned respite vacation will allow many more people to be able to maintain their family members at home, which would be their preference at that point, and it would be one available to support family care givers in doing that.

We feel it's a good investment to provide respite care in facilities, recognizing that if two facility beds are left open for respite purposes, then there are two fewer permanent residents in the facility.

1210

Mrs Sullivan: That's the difficulty I'm having. I think it's wonderful and in fact a very positive initiative to have respite care beds available in the facilities. Once again, however, we are looking at an aging population. We are looking at people who are on waiting lists with more severe physical and mental problems that must be dealt with when they're admitted to the home. There has been a freeze on new beds.

Where are those respite care beds going to come from? You're basically adding to the waiting list in making that promise. To open the beds up, you will have to wait for someone to die in a nursing home or in a home for the aged. That's how they will be opened up, and therefore somebody else who has the need for that space will not be able to have the facility-based care he or she requires.

Interjection.

Mrs Sullivan: Parliamentary assistant, this is a policy question. I'm not attacking the ministry people. Please let it be shown.

The Chair: Just very briefly, please, parliamentary assistant.

Mr Wessenger: I certainly acknowledge the point you're making. What you're saying is that if you provide these beds, you are diminishing from the stock of permanent beds. However, I think there's certainly an assumption made that we have an overall appropriate number of beds in the province of Ontario. We have a maldistribution of those beds, and I think that is recognized.

I don't want to go back to staff on this particular question, but I'm wondering if we're going to take that into account in the setting up of respite beds. For instance, I'm just thinking of my own regional area. We have a surplus of beds in part of the area and we have a shortage of beds in another part. It would make more sense in the respite bed situation to try to open up the beds in the areas where you have the surplus rather than the areas where you have the shortage. I'll have to ask staff if they can comment on it. The issue is raised—

The Chair: I think the issue's on the table at this point.

Mr Wessenger: It's an interesting issue.

The Chair: I regret, but we still have one more witness and I really must urge us to move on. Gentlemen, I want to thank you very much for coming again. I think you can see you've raised a number of issues which the committee will be dealing with.

Mr Cutler: Thank you.

VILLA CARE CENTRE

The Chair: If I could then call on the representative from the Villa Care Centre, please. Thank you for coming before the committee and also for waiting for your turn at the table. If you'd be good enough to introduce yourself, then please go ahead with your presentation.

Mr David Jarlette: My name is David Jarlette. I'm the administrator of the Villa Care Centre in Midland. It's a 109-bed nursing home. I come to you not as an institution. I've come here to speak on behalf of our residents, because it's our residents that will be affected by changes to Bill 101.

There may be many groups that are trying to derail long-term care reform. I'm not one of those people. I think what I'm going to be bringing up is just some concerns with portions of Bill 101 and its omissions. We want to see the bill passed as quickly as possible and we're in great support of it.

I think a little bit of history dealing with residents in nursing homes is that we haven't been adequately funded in comparison to other institutions, such as the municipally run homes for the aged, and that has resulted in our residents not having the ability to receive the same level of services for our residents as residents in other types of institutions, whether they be charitable homes, municipal homes or nursing homes. In 1989, for people who are not aware, there was a lawsuit put against the provincial government on the grounds of discrimination and inequitable treatment of residents in nursing homes compared to those in municipally run homes for the aged. The court found no discrimination, but it did urge the government to move on and deal with the inequities.

This issue is still in the court systems and is awaiting hearing at the Supreme Court of Canada, so it's been a long-term concern with respect to funding and our ability to provide quality services to our residents for quite a number of years. We are pleased with the government's attempt to develop the same set of rules and more equitable treatment for all long-term care facilities and we strongly endorse that.

We see that there is no government accountability to maintain equitable and consistent services to meet resident needs across all of Ontario, and we've seen in the bill that there's an ability to fund different institutions for different programs. I think we need to look at the fairness, no matter whether a resident is in a charitable or not-for-profit or for-profit or home for the aged. It's the resident who suffers, and I think there has to be consideration given specifically to the residents when you're really looking at equity for them.

We're concerned with the role of the placement coordinator, the lack of choice of applicants, the lack of appeal for the applicants and the lack of appeal for the facility, because it can be quite difficult when we're looking at our waiting lists, a resident coming in. An example of that may be that resident who might be quite aggressive and noisy. We have a four-bed ward where four residents are staying in that room. Placing a resident who could be aggressive and quite noisy in that room could be very disruptive to the quality of the life of other residents in that room. As a facility, we have to ensure the rights and the quality of life for the residents who are currently in our facility, as well as ensuring that when we bring a resident in, we're providing him or her with good quality care, and we can meet that too.

We are concerned that the bill sets up a more adversarial approach to inspections. From being in the long-term care field for many years, at one time we had an inspection system. It was quite adversarial. A lot of times things just didn't get done because of that approach. The approach of compliance, working together, does work. Things do get resolved and the quality of life of the residents does improve under that type of system.

In summary, the bill leaves too many issues to regulations. It provides too many powers for government and inspectors, without requiring a corresponding measure of accountability. The bill holds facilities accountable for providing for all residents' needs without ensuring that funding will be provided to make this possible.

I feel that we must go forward with the bill. Our residents have waited a long time for it and we must end the discrimination based on the type of facility a resident is in. As a facility, we're quite prepared to work with the government, work in partnership and hopefully ensure that the process of reform works well for the residents of the facilities. Thank you.

The Chair: Thank you very much, and thank you for coming down from Midland this morning to be with us. We'll begin the questioning with Miss Carter.

1220

Ms Jenny Carter (Peterborough): Thank you. Now you did state that, like many others, you had great concern with the unfairness of the funding system as it was previously, and of course that has been addressed in Bill 101. Also, we have the three envelopes that are going to cover—of course people are going to contribute to their accommodation, but that is going to be funded equally across the board—we're going to have the envelopes for things like spiritual needs and so on and we're going to have the care and the medical side also funded separately.

Now, given this bill, do you feel there's anything in the funding system, as suggested, which is not fair, or does it

solve that problem?

Mr Jarlette: I don't think the bill is addressing that. I believe it addresses that funding can be available for approved programs. I think maybe an example I could give you would be our physical facilities, the actual building, its design. Our facility was built in 1976. The type of residents we admitted in 1976 required quite considerably less care than they do today.

Problems with that? Examples are dining room space—when people are in wheelchairs in dining rooms, they take up a lot more space than residents who could previously walk down to the dining room and sit in a chair; just moving people on elevators. As an example, you can only put four wheelchairs in an elevator to transport or assist residents down to a dining room in a multi-floor facility, but a lot more residents could be in an elevator if they're walking.

These sorts of changes, with the types of residents we have, if we don't have the appropriate capital funding to build, renovate and keep our facilities up to snuff, that affects the quality of life of the residents. So if government gives special grants or capital improvement grants to, let's say, the not-for-profit sector, not-for-profit residents are going to be receiving the benefits of a much nicer physical facility than residents in a nursing home. I don't think that's necessarily fair.

Ms Carter: It was my understanding that residents who had a high level of care need would not be assigned to homes that were not physically capable of handling them.

Mr Jarlette: I think what's happening now is that traditionally the extended care program was from 1.5 hours of care up to, I believe, about 2.5. We're finding in our facility in Midland that approximately 40% to 50% of the

residents really have a chronic care level. That's far and above what we were initially designed, funded or staffed to accommodate

Ms Carter: So you are feeling pressure at this time?

Mr Jarlette: We are feeling quite pressured, yes.

The Chair: Thank you. Mrs O'Neill.

Mrs O'Neill: I'm glad you have been able to present your case, because it seems the general consensus about Bill 101 as it was presented initially was that this is level-of-care funding, this is what we've been waiting for for ever; it's here now. You're suggesting—and others, but maybe you have been more explicit—on the capital side, there are absolutely no mentions of capital or a commitment of capital, whether it be for increased care needs or whether it be for updating of present facilities. I presume that is your concern, at least one of your concerns. I'd like you to say a little bit more about that because, as I say, you seem to be the group, particularly the nursing homes, that this bill should have satisfied.

Mr Jarlette: The facility that I operate is in compliance with the Nursing Homes Act. I am not running into a problem of non-compliance and having to rebuild. I guess the point I am trying to make is that I think the types of residents that we're going to be caring for in the future are going to be requiring a lot more care. I think in future the facilities are going to have to be adapted, renovated and changed to meet those different care needs for those residents.

Mrs O'Neill: Do you feel there is any mention in the bill about capital?

Mr Jarlette: There is no mention, to my understanding, of capital in the bill.

Mrs O'Neill: And that's one of your concerns.

Mr Jarlette: We are quite concerned about that, because if we don't have the capital funding

Mr Jarlette: And we are quite concerned about that because if we don't have the capital funding, eventually we won't be in business because of the fact that we won't be able to keep our facilities up to acceptable standards in the long run.

Mrs O'Neill: Thank you.

The Chair: Thank you again very much for coming before the committee and expressing your concerns this morning.

The committee stands adjourned until 2 o'clock this afternoon.

The committee recessed at 1226.

AFTERNOON SITTING

The committee resumed at 1408

The Chair: Good afternoon, ladies and gentlemen. The standing committee on social development is meeting to examine Bill 101, An Act to amend certain Acts concerning Long Term Care. Just very briefly, before we begin the afternoon's proceedings, I would like to call on Alison Drummond to make a note about a document that she's given us.

Ms Alison Drummond: This morning, everybody got a memo from research looking like this. Could you tear out the witness sheet from your summary of submissions that you received on Tuesday afternoon and replace it with this? What happened was our computer went down at the office and I didn't realize that the witnesses from Ottawa and Kingston are all in the brief but they're not in the list of witnesses. So those codes can be a little obscure without this to let you know who's who.

The Chair: Never trust those computers.

ROYAL CANADIAN LEGION

The Chair: Our first representatives today are from the Royal Canadian Legion, Kingston branch. We want to welcome you to the committee. Would you be good enough just to introduce yourselves, and then please go ahead with your presentation. We have received a copy as well.

Mr Dave Gordon: My name is Dave Gordon. I'm the deputy district commander of the Royal Canadian Legion, District G. To my right is Jim Margerum, who is a district commander, and I believe presented a brief to you in Ottawa when you were there.

The Chair: Welcome to you both.

Mr Gordon: Thank you. As a part of the Royal Canadian Legion, our prime responsibility is to ensure that veterans and their dependants receive the care and assistance they are entitled to. We must make sure that we monitor the policies, programs and delivery systems which will meet their needs and that we recommend and/or lobby on their behalf to implement necessary corrective measures.

As a part of our mandate, we also play a prominent role in our communities to ensure our seniors, youth and disadvantaged are assisted and protected. The legion's involvement and support we have provided and will continue to deliver to eastern Ontario is a matter of record.

Our problems with Bill 101 and long-term care:

(1) We agree with and express the same concerns as our colleagues' briefs previously presented to this committee regarding: (a) the admission standards regarding eligibility, new provincial standards vis-à-vis veterans' health care regulations; (b) removal of extended/long-term care, level II designation and conversion to chronic care beds; (c) the failure of the province to fulfil the responsibilities of keeping veterans' designated beds in service which were transferred from Veterans Affairs Canada, ie, 45 chronic care beds in Sunnybrook, Toronto; (d) not putting into service the beds being closed at the psychiatric institute in London—approximately 160—where they are badly needed in

northern Ontario in particular, and other areas in Ontario; (e) the new coordinated placement service requirement to ensure veterans' priorities are recognized and respected, as guaranteed by federal legislation.

(2) In eastern Ontario we are extremely concerned that the new long-term care redirection has a serious void. With the designation of chronic care beds and the urgent direction of the province to put extended care level residents or patients back into the community, we see a lack of facilities and programs and support systems. Sufficient housing and accommodations do not exist to provide for the semi-independent domiciliary or sheltered needs of seniors and other disadvantaged. We recently opened a 44-unit seniors' housing complex in Kingston called Legion Villa in an attempt to help these people live in dignity and comfort. There is a need for more supportive semi-independent accommodation

(3) Once again we express our colleagues' dismay that veterans' priority beds and veterans' rights, transferred from the federal government and paid for, are not even mentioned or indicated in Bill 101. For that matter, nor are the veterans

In conclusion, while we have criticized objectively, we're working actively with the province and others to resolve and develop the infrastructure and facilities needed in eastern and, indeed, all of Ontario, to look after the needs of seniors, veterans and the less fortunate.

Mr Chairman, I thank you for allowing our presentation of this brief this afternoon and we'll be happy to respond to any questions.

The Chair: Thank you very much. We'll move right to questions.

Mrs Sullivan: This is an interesting presentation. As a matter of fact, my colleagues and I were discussing the legion presentation which was made in Ottawa at lunch today. I want to ask the ministry and the parliamentary assistant to the minister two questions, just so we can further our own understanding of this entire situation and see where potential amendments are.

Can you advise us where and how the veterans' health care regulations vary from provincial standards with respect to eligibility for admission to long-term care placements? Secondly, what is the intention of the province in terms of its dealings with veterans' rights accommodation, where there is a contractual agreement with the federal government in relationship to those beds?

Mr Wessenger: I will answer part of the question first and then refer it to ministry staff for the balance.

First of all, as you may know, Bill 101 does not relate to any of the priority beds that now exist, because they all exist in chronic care hospitals and this bill does not deal with chronic care hospitals, so the priority will still remain in that aspect. The issue has been raised with respect to the question of what is going to happen in the future with respect to the Perley Hospital. There is a transfer agreement that has been entered into between the federal government and the provincial government with respect to

those priority beds. I have read the provisions of that agreement and in my opinion that agreement provides that the matter of placement in the priority beds in the long-term care facility, if it becomes such a facility, will still continue through the federal process.

Of course, a judge might find an interpretation other than mine, but that is my interpretation upon reading the agreement. It's certainly the intention of the ministry to respect that priority. The minister will be writing a letter to confirm that aspect. Also, the minister has certainly expressed a willingness to meet with the legion in order to discuss the matter further to help clarify the situation.

Mr Jim Margerum: If I could comment on that, Perley and Rideau Veterans' is not a hospital any more; it's called a health centre. It has not been designated as a hospital. The beds under chronic care are in long-term care. In the old designation there was level 1 to level 4, level 4 being the heaviest care requirement. Those beds that were to go originally into the Perley and Rideau Veterans' Health Centre were 175 long-term care, which were up to level 2, and 75 heavy care, which were level 3 and level 4. In the process of developing the long-term care bill, 101, that designation was removed and they're all called chronic care beds. They're not called as you suggest.

The veterans' health care regulations very specifically stated the type of requirement for eligibility to get into those beds. The new agreement specifically states—and I say "specifically states"; we've had it checked legally—that the new provincial long-term care admission standards yet to be enacted in place are the admission requirements. I suggest that they overrule veterans' health care regulations. The problem we have with it is that if the federal government is transferring the responsibility along with the dollars to provide the facility, its requirement should transfer with it.

Mr Wessenger: I'm going to have ministry staff comment on that because we certainly have a disagreement with that interpretation. I'll ask ministry staff to further elaborate.

Mr Quirt: Just to clarify the status of the Perley Hospital currently, it is now a chronic hospital and will continue to be a chronic hospital until the new Perley and Rideau Veterans' Health Centre is opened. When that new centre is opened, it will be funded as a long-term care facility and will no longer be a hospital when that new facility is open.

The transfer agreement that was signed between Veterans Affairs, the province of Ontario and Perley Hospital, in our opinion, maintains priority access for veterans for 250 of those new beds. I know that there are two clauses on the same page and I can understand why you have a different impression.

Mr Margerum: There are five clauses.

Mr Quirt: It's the intention of the Minister of Health to write to Veterans Affairs to reconfirm her understanding of the agreement, and her understanding is that priority access will be continued for those 250 beds following construction of the new long-term care facility. I would note as well that any veteran being admitted to that new facility

would have the opportunity to receive whatever service at whatever level he needed in that new setting.

Mr Margerum: I would suggest, with all respect, that the original draft agreement which was provided to us by Veterans Affairs Canada included admission standards that related to the existing facilities being the Rideau vets' home and the Perley Hospital. That was in here. There were no grandfather clause requirements, nothing pertaining to new provisions to be developed by the province.

When the final contract or transfer agreement came out, there were five clauses specifically relating to admission. Our argument is very straightforward: If what we are concerned about is not the case, why are the clauses in the agreement? They shouldn't be in there. The language in this was sufficient to cover.

I read it again for the record: "The admission process at the Perley-Rideau Veterans' Health Centre"—and that is a new facility—"(a) In accordance with the provincial redirection of long-term care, the admission process to the Perley-Rideau Veterans' Health Centre will be coordinated through the services coordinating agency. The role of this organization, the admission committee of the Perley Rideau vets' centre and the practice and procedures of the admission process shall be established in accordance with long-term care reform policies and guidelines which may be in place from time to time."

That is exactly the clause that bothers us, and in here the clause is an all-including clause that states specifically all the facilities.

1420

Mr Quirt: I don't have the document in front of me, but I think on the same page there's a reference back to the continued priority access for veterans to those 250 beds. My understanding is that Veterans Affairs Canada feels it does have priority access to those beds or it wouldn't be interested in paying for a big part of the facility; and as I mentioned earlier, the Minister of Health is under the impression and certainly signed the agreement in the spirit of maintaining priority access for veterans and is willing to write to reconfirm that position.

The minister is also interested in meeting with representatives from the legion to talk about this issue and the issue of priority access generally to chronic hospitals as well.

Mr Gordon: When?

Mr Margerum: We've tried for a year and a half, sir, and we were unable to get that meeting with the minister.

Mr Quirt: Mr Wessenger discussed the matter with the minister—

Mr Wessenger: A few days ago, yes.

Mr Quirt: —two days ago and she indicated her willingness to meet with you, and I suspect her office will be in contact with you.

Mr Margerum: I go back again to reinforce the argument on the clause on page 14 of the transfer agreement, which is clause 33(b) 1. "The admission committee at the Rideau vets' home, which reviews all applications for admissions and establishes the appropriate type of care and

health services required...the department shall be represented on the admission committee by the director or his delegate." Those are existing facilities.

Now, clause 2: "The admission committee at the Perley-Rideau Veterans' Health Centre"—this is the new one—"which will function in accordance with the long-term care redirection and provincial enactments." It does not say Veterans Affairs Canada health care regulations. It does not say it. The words are missing. We can only assume that what's in there is what would go by in a court of law or in a dispute.

The Chair: I'm going to continue with questions. You have a commitment that there will be a meeting with the minister where hopefully that can be resolved. Mr Wilson.

Mr Jim Wilson: Commanders, like you, I and my party aren't satisfied that a meeting with the minister or an exchange of letters between the provincial minister and the federal government will have any weight at all in law should this come down to a court case.

I think you need protection for priority placement for veterans and protection of the current federal-provincial agreements, and I wrote legion command when this was first raised some four or five weeks ago to express the fact that we have drafted amendments to try and give you that protection.

I also want to say that as Health critic, one of the first things I did was to visit Perley Hospital and to review the plans for the Perley-Rideau Veterans' Health Centre, the new health centre, so I'm very much aware of it.

This is a contentious issue, and because the government tells us that its intentions are good, I want to ask the parliamentary assistant, why won't you put your intentions in writing in this legislation? Why don't we write a clause into this legislation that says nothing in this act is to contravene any of the current federal-provincial agreements established to give priority access and placement to Canada's veterans? Why can't we do that and just make it absolutely clear, and clear for the courts? Even if you think it's redundant, put it in the act.

Mr Wessenger: We feel that it's clear in the agreement that the rights are protected, and to make an amendment purely to reiterate what's under a legally binding agreement would not particularly make sense. I will ask legal counsel. They may wish to comment further on this. I shouldn't be playing lawyer as well as politician.

Ms Czukar: I'm Gail Czukar, legal counsel with the Ministry of Health. I don't know that it would necessarily make it perfectly clear if we had something in our legislation. You would then have a conflict between provincial legislation, federal legislation and regulations and a federal-provincial agreement which is binding on the ministers. So I don't know that this will solve the problem. I think there are different legal opinions, as there were when the transfer agreement was negotiated, and it is something that has to be looked at.

The legion obviously has obtained legal advice that gives it an interpretation, we have an interpretation, and the federal government, which participated in the agreement, has an interpretation. I think the meeting that's been

committed to is probably the best forum for trying to work out where the best legal protection can be obtained. It's not clear to me that changing our legislation would be the best place to do that.

Mr Jim Wilson: Except that I'm a legislator; playing a shell game is not acceptable to me nor to the members of this committee. I want this issue resolved. You've known, Mr Wessenger, for quite some time that this issue was out there. It was brought up weeks ago in the hearings. You're only now getting around to having your minister meet with these people. It's bad enough that we have to do everything else in this legislation in a void; now you're telling us that another serious issue affecting Canada's veterans has to be done in a void and that we have to have some sort of faith that you're going to correct this in the long run.

I don't think that's good enough, and I don't think you should be asking the Legislature, which will be sitting in a few weeks, to deal with this legislation, to pass this, when there's an issue like this outstanding. So I think you'd better get your act together in the next seven days and bring us amendments forward next Tuesday to clear this up.

Mr Wessenger: Mr Wilson, I suggest that we do have our act together, and I suggest that legally binding agreements protect rights as well as legislation.

Mr Jim Wilson: Look, what you're saying is—

The Chair: Order, please.

Mr Wessenger: You're not a lawyer, Mr Wilson. I'll go on record as a lawyer saying that in my opinion the agreement gives protection to the legion. I may disagree with the legion's lawyer, but that's something to be worked out. If clarification is needed, an amending agreement or something of that nature just to clarify, I'm sure that can be worked out. I think it's clear that the intention is not to in any way detract from the priority beds, and certainly we're prepared to look at the best way of ensuring that, but we feel that they're protected now. There may be some additional things that can be looked at to be done. Obviously, the matter shouldn't be played politics with; we should look at it to see the best way to protect the interests of the legion.

Mr Jim Wilson: I'm not. If I were a legionnaire, I would be insulted by the treatment this government has given. Okay, I'm not a lawyer, but they've had legal advice. These are intelligent people. They've had to come before the committee many times now to drive this point home. I'm just not satisfied, and I'm going on record to indicate that I'm not satisfied with the government's response to this issue.

The Chair: I think at this point the issues are clearly on the table, and there's a difference of opinion which hopefully will be resolved before the legislation is enacted. I think at this point we have probably set that out sufficiently. I'd like to just provide the opportunity to either of our two witnesses, if there is any final point you would like to make, and then I'm afraid we'll have to move on.

Mr Margerum: I have one other point concerning it. If in fact there's no problem, as it's alluded to, if we have no problem, I begin to wonder, when I see the eligibility and admission standards put out by the Ministry of Health, I believe. One of the clauses in the introduction says it is proposed that persons currently on waiting lists for residential care will be required to meet the new eligibility criteria in order to be eligible for facility-based care. I make the point that veterans are on eligibility lists, and it does not say, "veterans excepted." It does not say that.

I make it very clear, as I go through the information, that I don't pretend to be a lawyer. I am not a lawyer; I'm a concerned citizen who's worried like hell about the treatment veterans are getting. When I see language like this, entire agreement clauses that specifically state that the minister is sending us a letter saying, "We agree with you; we'll look after it," that isn't worth a tinker's dam. What the clause says is that anything that is not written in this agreement is not binding. I am not a lawyer. I will not debate as a lawyer because I don't have the capability, but I'll state very clearly that this transfer agreement and Bill 101 do not recognize veterans' rights or veterans' priorities.

1430

The Chair: I think we recognize those points you have made, and made very cogently, not only here but in Ottawa. I think there has been a commitment made today, which we have all heard, that there is going to be a meeting with the minister. I think it's fair to say that the members assembled will be following up to make sure that the meeting takes place and that these issues will be dealt with at that time and, we hope, resolved.

Mrs O'Neill: Mr Chairman, we don't have a copy of the agreement. It's come up twice to this committee. Some members of the committee do have it. I really feel we should—

The Chair: Copies were distributed, I thought, in Ottawa—

Mrs O'Neill: No, we have not had it. I would be very conscious of it if we did.

The Chair: Oh, I'm sorry. Each caucus has a copy. We can make other copies. There's no problem.

Mrs O'Neill: I think it would be helpful. This has been a very high-profile item with this committee. We all should have access to that—

The Chair: We'll make sure each member has one, and we will, I'm sure, see that there will be a meeting with the minister.

Mr Margerum: There are two agreements. There's the signed agreement and there's the draft agreement. That has to be compared, to understand where we're coming from

Mrs O'Neill: We'd like to have both of those, sir, please.

The Chair: Thank you very much for coming. Just to reiterate, I think the arguments both in terms of the testimony in Ottawa and here today have placed all of those issues very clearly in the public record, which is what this committee hearing is, and we wish you the very best in

your discussions with the minister, which I would assume will happen soon. Thank you, and a safe trip back to Kingston.

Mr Larry O'Connor (Durham-York): Mr Chair, while the next people are coming to the table, I'd like to say something. This last discussion we just had shows there is a problem. The legion does have a concern. I just wanted to make a point that I'm sure Mr Wilson raised, that these people have a concern. The minister, through Mr Wessenger, has said she's agreed to meet with them. Perhaps he could take the message to the minister that they meet before we get into clause-by-clause, if it's possible for that to happen. I think basically what Mr Wilson and the people from the legion are saying is that they've got a problem and it's not going to do us much good if it comes after the clause-by-clause. If Mr Wessenger can take that back to the minister, I think there will be a little bit more comfort around this room.

The Chair: Thank you.

JOEL SADAVOY

The Chair: Just before recognizing the member, I would call on Dr Joel Sadavoy from the University of Toronto faculty of medicine, division of geriatric psychiatry, to come forward. Dr Sadavoy, welcome to the committee. Before we go too far down the road with the legal profession, I think we'll stay with the medical profession. We want to welcome you to the committee. Perhaps you might at the outset again identify yourself and your functions at the University of Toronto, and then please go ahead with your presentation and with the slides or whatever you're going to be showing us.

Dr Joel Sadavoy: First of all, thank you for the opportunity of addressing you. I am the head of the division of geriatric psychiatry at the University of Toronto, and I have other duties at local hospitals in the field. I am also the president of the Canadian Academy of Geriatric Psychiatry, which is a national group, and I am a member of the interfaculty group in geriatric psychiatry, which represents the five Ontario medical schools and their geriatric psychiatry services.

Wearing all of those hats, I come to present this view of the psychiatric aspects of long-term care reform. In doing so, I want to first acknowledge the fact that there is an advisory committee in geriatric psychiatry which has been developed. It began primarily as a discussion between the representatives of provincial hospitals and the ministry. That's largely where the discussion is occurring at the moment. I wanted to broaden the view of geriatric psychiatry and long-term care so that it could be incorporated, where appropriate, into the deliberations of this committee.

I will have to be somewhat of a magician, I think, to present slides. We don't have a projector.

The Chair: I apologize. I gather a machine at some point arrived and then disappeared, although it may have returned. If that indeed is the machine, perhaps we could have a brief recess to get it set up. "Is that the machine?" said the Chairman, hopefully.

Clerk of the Committee (Mr Douglas Arnott): Yes.

The Chair: It is. We will recess for a minute or two and get set up.

The committee recessed at 1436 and resumed at 1442.

The Chair: The committee will come back into session, and by the magic of modern technology, we seem to have got the system working, so please continue.

Dr Sadavoy: Thank you very much. This brief is presented to demonstrate the need for Bill 101 to deal specifically with the mental health needs of the elderly, the prime consumers of long-term care services. Within this group are the special needs of minority and ethnocultural elderly. The presentation is divided into two components: background data on psychiatric problems of the elderly as they relate to long-term care, and specific recommendations arising out of these data.

The management of mental health issues in long-term care is best viewed as occurring on a continuum, beginning in the community and running through the acute care system, especially the general hospitals, to the long-term care facilities; that is nursing, charitable and municipal homes. Psychiatric disorders are a central factor in service delivery at each level of the system.

At present, approximately 95% of those over the age of 65 continue to live in the community. In the United States, 90% of those over 75 and 80% of those over 80 reside in the community. As with many global statistics, however, these figures do not identify the level of illness and service needs of this population.

Formal psychiatric services are underutilized by community-dwelling elderly, and the majority of care is provided by non-psychiatric practitioners: 80% of the elderly with a psychiatric diagnosis are treated by non-psychiatric medical practitioners. Equally important is the finding that only 5% of elderly patients with psychiatric disorders who are seen by those practitioners are referred to a psychiatrist, and these tend to be only the most severely ill.

On first sight, it may seem encouraging to you, and cost-effective for general medical practitioners, to treat elderly patients, and to a degree this is true. However, there are important problems associated with this pattern of care, in particular, the well-documented, inappropriate use of medications and underdiagnosis of psychiatric problems, with attendant failure to find and treat reversible psychiatric disorders.

The scope of this issue is revealed when we look at the nature of the psychiatric problems that must be addressed in the community. Many of these problems are hidden and only come to the attention of psychiatrists or other health care providers when a crisis occurs. This is especially true of ethnocultural elderly that we'll deal with in a few minutes.

Within the community, therefore, there is a large pool of elderly patients often unrecognized who present a wide variety of disorders. Of special concern are the dementias—that is, failure of brain function due to organic illness—which occur particularly in those over the age of 80. In looking at these figures, it is important to be aware that for every demented patient living at home, there are care givers

who must be involved and who come under considerable

Depressive disorders affect over 15% of the geriatric population. They are especially important to identify because they are reversible and treatable in many situations. Anxiety disorders are also common, and in this group of special concern is the almost 5% of the population made up almost entirely of women who are phobic and quietly living lives of isolation and fear. Eleven per cent of the geriatric population has some form of psychosis—that is, loss of touch with reality—and based on our current knowledge, about 2% of this group suffers with alcohol or drug abuse problems.

Thirty-five per cent of all patients admitted to general hospitals are over 65. These patients stay 30% longer than younger patients, and based on current data, 40% to 50% of them, almost half, develop some kind of psychiatric disturbance. These figures are, I have to tell you, based on US studies. I think they are probably comparable in Canada, but we don't have specific data for this country that I know of

The majority of the problems of patients in general hospitals are dementia, as I mentioned before, delirium—that is an acute agitation which is usually secondary to a medical disorder and is often reversible and treatable—and significant depressive illness. Data from several studies indicate that psychiatric disorders in these settings of general hospitals tend to be markedly underdiagnosed. It is probable, for example, that two thirds of depressed patients in these hospitals are neither recognized nor referred for psychiatric assessment. So what is the relevance to long-term care?

Since the general hospital is often the last stop before a patient is placed in an institution, staff in these hospitals who deal with geriatric patients are especially concerned with the interface between the acute care sector and the long-term care sector. Often, patients who are transferred from acute to long-term care have become unable to manage at home, even with support, because of a psychiatric disorder. Consequently, rational decisions regarding placement of patients of the general hospital to the long-term care sector require a formal interface with general hospital discharge teams which are able to address psychiatric as well as medical and social needs.

Chronic settings: The staff of chronic care institutions rank behaviour disorders as the most pressing problems with which they must cope.

Based on US studies—and we have some confirmation from Canadian studies—up to 94% of residents in nursing homes have been reported to have a formal psychiatric diagnosis. Half to three quarters of these have dementia—that is, the progressive, permanent loss of intellectual functioning that I mentioned before—and many of these patients also have psychotic or depressive disorders. Of those who are newly admitted to an institution, one in five is delusional. They've lost touch with reality and they're often quite paranoid, suspicious.

Two thirds of residents in nursing homes have at least one behaviourial disturbance, and half of these residents are given psychotropic medications; that is, medications for psychiatric disorders or behaviour disturbance. This latter statistic is disturbing when we recognize that the reasons for prescribing drugs to these elderly often are poorly defined. A psychiatrist is rarely consulted or available, and follow-up by a physician is often poor.

The data are confirmed by a recent study by David Conn and his group, who surveyed Ontario nursing homes to determine the need for psychiatric services as perceived by senior nursing home personnel. In particular, the medical directors and the directors of nursing were surveyed.

About 600 of 1,148 nursing homes responded. Over 50% of these homes had no psychiatric service available and, equally important, almost 90% had fewer than five hours a month of psychiatric service, so that almost all the nursing homes in Ontario are virtually unserved by psychiatric specialists. I'm not talking about geriatric psychiatrists; I'm talking about any psychiatrist.

1450

As we saw earlier, up to 94% of residents in nursing homes have been shown to have a psychiatric disorder, but interestingly, when this group was studied—the medical directors and nursing directors—they estimated a prevalence of approximately 30%. This is a marked underestimate when compared to the data that we have from actual studies.

One of the most telling pieces of data from this study, which is confirmed by clinical experience, is that the most challenging and frequent problem the staff of nursing homes face is that of aggression, followed by wandering and depression.

I'd like to move on now and talk about some data with regard to ethnocultural issues and the elderly. This information derives from the preliminary report of the crosscultural geriatric psychiatry subcommittee of the division of geriatric psychiatry at the University of Toronto. The data are enclosed in the appendix to this report which you should have in hand.

In surveying all the data available, it is evident that ethnocultural groups do not seek out psychiatric services until a crisis arises. Consequently, this group is disproportionately represented in emergency and crisis services in hospitals and elsewhere.

When the ethnic origin and language of care givers do not match those of clients, there is a decline in the outcome of care. This leads to an increased risk of psychiatric institutionalization. Again, these data come primarily from US studies.

Ethnocultural groups show a different pattern of psychiatric disorder and therefore must be dealt with in a different way sometimes than their white or non-ethnic counterparts. In particular, psychiatric morbidity, the amount of psychiatric disorder, appears to be higher. For example, Chinese elderly women have a much higher suicide rate then their English-speaking peers. For those over 85, the rate, according to one study, is 10 times that of white counterparts.

Other mental health issues derive from loss of status, isolation, alienation from the dominant culture, discriminatory legislation, racism and mistrust of mainstream health care especially for mental health problems.

With regard to psychiatric care, the 1988 Canadian task force on mental health issues affecting immigrants and refugees found that there has been insufficient effort to make general community programs for the elderly accessible to ethnocultural groups.

The problems are further demonstrated by census data, the Ontario 1991 census. Those over 65 make up approximately 11% of the population. Of these, about 24% are non-English or French-speaking.

The 1986 Ontario census showed that of the elderly population 13% were Italian, 10% Chinese, 7% Portuguese, 4% South Asian and 3% Latin, Central or South American. One of the problems of presenting on this topic is that inevitably there will be groups that may be left out. That is certainly not the intention here, but these are the data that we have at our disposal.

While the data on ethnospecific mental health problems of the elderly are very limited, a variety of problems has been identified to this point by our group. In particular, there is an absence of ethnospecific geriatric mental health clinics available. There is a failure of programs in the longterm care system to take special cognizance of the needs of this population. Staff are essentially untrained in dealing with ethnospecific problems and there are few resources for language interpretation to assist geriatric mental health

We have a number of recommendations to suggest. With regard to the ethnospecific issues, our group recommends that ethnic and cultural factors be central considerations in the development of routine care plans, extraordinary care plans, training of placement coordinators, criteria for establishing quality assurance programs and the development of in-service training programs. We will be able to make more specific recommendations as our study continues.

With regard to general mental health recommendations, it is recommended that routine care and all plans of care for the elderly include mental health issues along with the physical, social and environmental. Routine care, as defined in the act, should require specific management of emotional and behavioural disorders. This is most important, since these disorders in facilities are often missed or ignored in long-term care facilities until a crisis arises.

Care plans for extraordinary care should specifically designate psychiatric needs. In this regard, we would suggest that it is most important that the availability of or requirement for funding for extraordinary care of psychiatric disorders be specified at the outset of the reform process. Just in that regard, one of the problems that institutions have is that they do not have the resources to access mental health care consultation and so, in part because of that, those resources are not made available and are not sought by the institutions themselves.

We suggest that one criterion for granting institutional licences should be the capacity of institutions to provide psychiatric care for disorders of mental health. In particular, we recommend that institutions be required to ensure the availability of regular psychiatric consultation and treatment. Institutional licensing criteria should also include a requirement for staff training in psychiatric disorders, adequate staffing patterns to handle disturbed, aggressive,

wandering or otherwise impaired individuals, as well as appropriate physical facilities such as closed, safe environments and observational facilities. We make that recommendation recognizing the limitations that exist in many institutions.

The effective function of the placement coordinators is central to the success of long-term care reform. Placement coordinators will be most effective if they are trained and knowledgeable in the types of psychiatric disorders most prevalent in the elderly, if they are trained in knowledge of the mental health care needs of the applicants they will encounter who have various types of psychiatric problems and if they have available to them psychiatric consultation on a formally designated basis. In other words, it will not be enough to establish a principle that this should happen. Some kind of system must be put into place to ensure that facilities are readily available to placement coordinators to obtain the kind of consultation that they need.

In determining eligibility for admission to an institution, disorders of mental health should not be a cause for refusal. This currently is the situation in many institutions. However, for the most difficult problems it may be prudent to identify and designate specific facilities which are able to provide the extraordinary psychiatric care necessary in some cases.

Not all institutions are able to deal with the most difficult of the psychiatric problems they will be presented with. The argument may be put forward that such patients should be in primary psychiatric facilities. Unfortunately, the reality is often more difficult to implement. The Ontario hospitals may be one resource to make use of in that regard, but whatever we do, I think that nursing home facilities and chronic care facilities are going to end up having to deal with psychiatric disorders, and serious ones.

In determining the adequacy of quality assurance programs, all such programs should include evaluation of the diagnosis and management of psychiatric disorders together with the efficacy of consultation and treatment resources of these disorders. The level of care needed by a resident of a facility will be influenced strongly by the presence of psychiatric problems. The act will be strengthened if psychiatric and emotional disorders are indicated as special factors in determining level of care.

Moreover, service is improved by the special designation of beds for psychiatric disorders with in-service training for the staff of such units. It is recognized that not all institutions will have the capacity or willingness to provide these facilities. Consequently, certain institutions in each region may be developed to manage psychiatric problems.

Finally, I re-emphasize that in-service training should specifically include training in the management of disorders of mental health.

Those are the data and recommendations we have to present. Thank you.

1500

The Chair: Thank you very much for that presentation, for the recommendations and the detail in it. It's very helpful. I think I'm safe in saying that is the first presentation I believe we've had from the psychiatric perspective

and we're very grateful for it. We'll get right to questions, beginning with Mr Wilson.

Mr Jim Wilson: I'll just add to what Mr Beer has said. We very much appreciate your bringing your expertise and knowledge to the committee's attention.

I have a couple of questions. It seems to me you make an excellent recommendation in terms of the fact that the psychological status—I don't know what the non-layman's term is—of an individual should be taken into consideration when determining levels of care. I'm not even sure, though, who's doing the pre-admission assessments in this legislation. It seems to me that's where you're most appropriate with regard to that point.

I'm going to refer this open-ended question to the parliamentary assistant, because I think that will be dealt with in regulation. Maybe we can get a ruling here now on how pre-admission assessments are to be done and whether psychological factors are taken into consideration with a qualified psychiatrist.

Mr Wessenger: I'll ask ministry staff to respond to the question of how it's going to work on the assessment and placement coordination, because I think that's really the question. Is that true?

Mr.Jim Wilson: Yes.

Mr Quirt: The preadmission assessment to determine whether a person's long-term care needs should be best met in a facility would be done by the placement coordination service initially, would involve a multiservice agency eventually and would involve the attending physician of the individual in question. Should that multidisciplinary assessment indicate that there would be the need for a psychiatric assessment or review of the client's mental health status, then the physician could refer that client to a psychiatrist for an assessment or whatever treatment might be necessary.

Once the person was admitted to the long-term care facility—you mentioned levels-of-care funding. The resident classification system does take into account the nursing and personal care resources that a client might need as a result of the behaviour he exhibits. That's something that doesn't factor into eligibility for extended care now very much. Someone can score quite highly in the resident classification system on the basis of behaviour alone, given that it has a significant impact on the staff time required to appropriately care for that resident.

Mr Jim Wilson: I gather what the witness has been saying, though, is that even with the new system, unless there is a requirement for the placement coordinator to actually consult a psychiatrist and be given the resources to be able to do that—I guess that leads to the question, in the current situation, is it that the institutions don't have the resources or the staff don't have the training and knowledge? The referral rate for psychiatric consultation is abysmally low, and unless there's some sort of requirement in the assessment and in the regulations to include psychiatrists as part of the assessment team, I don't see us really solving the problem.

Dr Sadavoy: First of all, I think the sophistication around psychiatric disorders varies widely from place to

place but, in general, I would say that it is low unless there are dramatic symptoms that the patient presents.

The question of whether a psychiatrist per se has to be involved is another issue. I think it's probably unrealistic to think that psychiatric manpower will be sufficient to provide a psychiatrist at each level, including the placement coordination level, but there are other ways of constructing the screening instrument; for example, to look for the more subtle signs of disorder which can have a profound impact on the way an individual copes and adapts to an institution as well as on the nature of the treatment that has to be put into place.

One of the concerns we have is that, to my knowledge, specific attention has not yet been paid to the need for an instrument to screen in this way. I may be mistaken about that

Mr Quirt: There is a screening assessment instrument under development that has been under development for at least two years now and has been tested with people in the home care program and, I believe, with people who are working in placement coordination. I can't recall whether there's a specific reference to referral for psychiatric assessment in that instrument, but there's certainly an interest in the clients' mental health state and the fact that they may be depressed or the fact that they may have a cognitive impairment.

Certainly the intention would be to try to determine whether the behaviour the client was exhibiting was as a result of a psychiatric illness or as a result of inappropriately prescribed medication. The intent of the assessment is to take a multidisciplinary and holistic approach to measuring the service requirements of the particular individual. We can certainly check to see if that instrument would prompt the question as to whether or not psychiatric assessment would be appropriate to that particular client in determining how best to meet her needs.

Dr Sadavoy: It might be helpful in that regard for two things to happen. First of all, you may want to have that instrument reviewed by geriatric psychiatrists in consultation.

Secondly, merely identifying the problems or having an instrument is not the end point, of course. There is a necessity, I think, for the placement coordination function to have attached to it a formal liaison with a backup service that can provide the expert consultation should something arise out of the screening instrument.

Mr Gary Malkowski (York East): That was very comprehensive and well presented from a psychiatric perspective for geriatrics and for people with disabilities. I'm curious to know, though, before the development of Bill 101, were there any studies to show if there were any geriatric or psychiatric experiences where they actually experienced discrimination trying to get into long-term care facilities because of the need for a lot of care and the requirements that would entail?

Dr Sadavoy: Indeed there are numerous clinical instances in which institutions bar the door if someone does not conform to their particular standards of behaviour. In other words: Are they going to require a lot of care, are there indications of aggression and, in particular, do they

suffer from Alzheimer's disease? If one writes that down on an application form in the current system, it is often the case that institutions will refuse admission

Mr Malkowski: Just to follows up on that point: This legislation, Bill 101, do you believe this will actually then end up helping some of those senior citizens with psychiatric problems get into long-term care facilities? Do you think this will actually help those people? Will it improve a bad situation or, in your view, do you think this might make it worse?

Dr Sadavoy: I don't think it'll make it worse, but I think it will improve it only if we are able to provide the kinds of services necessary to deal with these problems in a more effective way within the institutional sector of care.

Mr Malkowski: My very last point then, if I may. Some of the ethnocultural groups you mentioned: Do you feel specific admission criteria are needed for eligibility for some of those people? Would you like to see added perhaps a psychosocial criterion? Would that help for some of those groups to see if that would be more a success rate to get some of those people in, to get the resources those people need?

Dr Sadavoy: I think there's a lot we don't understand about the referral pattern in other communities. We don't know, for example, the prejudices that may exist within the communities towards the traditional health care system and there may be an avoidance within communities—we're pretty sure there is an avoidance of traditional health care for a variety of reasons.

I think, rather than setting specific criteria for admission for various subgroups of elderly, we are probably going to be more successful if we increase the sensitivity of the system to the kinds of problems individuals in these communities may have so we can identify when they are in trouble and find them and offer help. Additionally, these problems probably are not going to be resolved if we impose something from the top, from the dominant culture, if you will.

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I think the development of programming for these communities will be most effective if it happens from within the community itself. That's the goal of our current work, which is to try to determine, first of all, what the problems are of the elderly within those groups, what the services are that currently exist and what the service requirements may be for the future. Once we have that information we'll be able to make specific recommendations, some of which may address the question that you pose.

Mrs Sullivan: I'm interested in this discussion. We have certainly learned, before committee and in other instances, from homes themselves of the increasing psychiatric difficulties with patients, largely because of the increasing age of residents who are entering homes, residents who, 40 years ago, may not have survived long enough to have the symptoms that are evident today and are in fact living to express them, frequently with violence. And there are issues associated with, by example, the questions of security of the nursing staff, questions related to ongoing skills of the nursing staff, in that staff tend to

have been trained in other aspects of geriatric care rather than in psychiatric geriatric nursing.

I was glancing through the manual and I don't see, either in the description of the home and the services which are provided to residents or in the standards for admission and medical care, any reference to psychiatric care. The closest thing I can find is that the medical director and the attending physician have an opportunity to refer to physicians with specialist knowledge. I guess that would be the input for the psychiatrist.

Earlier today we spoke about homes which could not meet certain needs because of physical limitations. In my view, because of physical limitations there are certain reasons to not admit certain psychiatric patients to certain homes. If, by example, a home does not have the ability to provide a secure facility, certain Alzheimer patients ought not to be in that facility.

We asked earlier if the province was going to assist with money in terms of upgrades. There's going to be more demand for medical care provided in the nursing homes. Is there going to be assistance, if the province is going to say that the psychiatric patient who is aggressive or who is a wanderer must be admitted to any home, that the home will have the appropriate facilities to deal with that patient, who is both a patient and a resident, and that ongoing psychiatric care will be made available apart from the medical model? This is a mental health model.

What I'm asking is, is every home going to be required to accept all patients no matter what level of psychiatric illness and, if so, is the province going to come up with the capital dollars that will be necessary (a) to upgrade skills and (b) to upgrade facilities?

Mr Wessenger: I think it's fair to say that the whole concept of this reform and the whole concept of placement coordination is that applicants will be placed where the services are appropriate. Obviously some services do not have either the physical facilities or trained staff to accept all applicants. I think it would be fair to say no, not every facility is going to have to accept every type of applicant, for the simple reason that you have to look at the ability of that facility to service the needs of that applicant. I think that's the first thing to say.

Also, I might just add that we're awaiting of course the chronic hospital report. There may be a particular role that the chronic hospitals may also play in this whole question. I don't know whether ministry staff wish to add anything to what I've said, but I think I've pretty well covered the question.

Mrs Sullivan: It's unfortunate that we don't have that report in front of us now so that we could deal with these issues in their totality. Will the ministry then, in further developments to the manual, consider the question of psychiatric assessment and ongoing psychiatric care as part of the development of standards?

Mr Wessenger: I certainly will ask ministry staff to take that into consideration. Ministry staff might like to make some comments on that.

Mr Quirt: The reference that you pointed out was the accurate reference in terms of the option and requirement

for the attending physician to make whatever appropriate referral for specialized assessment or care. It would be the attending physician who would refer the client to a psychiatrist if a psychiatric assessment or psychiatric treatment were necessary.

The program manual will deal with issues related to nursing care with respect to providing a secure environment and appropriate programming for people with cognitive impairments. As has been pointed out, that's a growing percentage of the clients in our facilities.

With respect to capital funding, which was your other question, currently the government has a capital funding program for the homes for the aged program. The bill before you contains a provision to allow for the development of a capital funding program for not-for-profit nursing homes.

Mrs Sullivan: And the commercial sector?

Mr Quirt: The capital funding program is under review currently with a view to targeting the capital resources to those facilities most in need of upgrading. In virtually all the capital projects we've been involved with, we've encouraged or required the development of a secure area within the facility appropriately designed to meet the needs of people with cognitive impairments.

The Chair: I'm afraid we're going to have to bring this to an end, but I want to allow you a final word, Dr Sadavoy.

Dr Sadavoy: Thank you very much. Very quickly, there are two issues. First, homes often don't have the option of deciding whom they're going to admit because these problems grow within the institution as often as they are admitted to the institution. There has to be provision for dealing with them, regardless of whether patients are admitted initially or not.

Second, the regulation as written, the option to refer, has functioned in a very inadequate way. When we recognize the scope of the problem we're dealing with, it is perhaps the dominant issue within a nursing home beyond the physical problems. I would urge the committee to consider altering that regulation so that there be more specific attention paid to these problems and remedies stipulated. Thank you.

The Chair: Again, on behalf of the committee, thank you very much for coming. I think you've raised a whole series of issues in a very specific and particular way that may have been bouncing around a bit in our heads, but you've really focused those. We thank you very much for coming this afternoon.

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VICTORIAN ORDER OF NURSES, SIMCOE COUNTY BRANCH

The Chair: I would now call on the Victorian Order of Nurses, Simcoe county branch presenters, if they would be good enough to come forward. I know we have some Simcoe representatives around the table. I watch them swell with pride. Yesterday it was York region. Today it's Simcoe county. Who knows about tomorrow.

We want to welcome you to the committee. If you'd be good enough to introduce yourself, then please go ahead with your presentation.

Ms Melody Miles: Mr Chairman and members of the standing committee on social development, my name is Melody Miles and I'm the executive director of the VON, Simcoe county branch. I am pleased to have the opportunity to appear before you this afternoon to comment on the proposed amendments specific to Bill 101, An Act to amend certain Acts concerning Long Term Care, and to address long-term care policy issues in general.

As you are likely aware, the VON is a national, not-for-profit voluntary health care organization that addresses the health needs of people across Canada through services provided by nurses, other health professionals, home support service workers and volunteers. As a major provider of nursing and other services in the home and community, the VON believes that individuals have primary responsibility for their own health; that the value and dignity of human life is respected; that access to comprehensive, compassionate, family and community-centred health and support services is the right of all individuals; that volunteers make a valuable contribution by extending and complementing the services provided by health professionals and home support workers; and finally, that community health services of assured quality are essential.

Since June 1990, VON has been involved in ongoing dialogue with the government specific to proposals for reform of the long-term care system. On a personal note, I find being afforded the opportunity to participate first hand in the consultation process to be most encouraging.

With regard to the geographic and demographic profile of Simcoe county, the Simcoe country branch of VON, which this year, incidentally, celebrated its 70th anniversary, services the largest and most centrally located county in Ontario. Geographically, Simcoe county is bordered by Georgian Bay to the north, the counties of Grey and Dufferin and Peel region on the west, York region on the south and the counties of Durham and Victoria and Muskoka region on the east. Several of its larger centres, including Orillia, Collingwood and Bradford, are situated on its boundaries and thus have service linkages which often are outside of Simcoe county. Simcoe county, split almost evenly between rural and urban populations, is a very decentralized community consisting of 35 municipalities and two Indian reserves, Christian Island and Rama.

Standing at a population of 288,705, Simcoe county is one of the highest growth areas in the province. The number of people aged 65 years and over is increasing at the greatest rate, with the subpopulation of those 75 and over experiencing growth of 25% between 1981 and 1986. It is projected that the population over 65 years of age will increase from 30,735 in 1986 to 40,000 in 1996 for a growth rate of 30%.

Specific to ethnicity, 60% of the residents of Simcoe county declare a single ethnic origin: 71% British, 8% French and 20% other ethnic origins. Simcoe county is a designated area for French-language services due primarily to the French settlements in the north planning area of Penetanguishene and Tiny and the francophone population at CFB Borden in Essa township. The native population is strongly represented in Christian Island and Rama and the Portuguese population prominently represented in Bradford.

With respect to VON services, the VON, Simcoe county branch, provides a variety of services throughout the county, both in-home and in long-term care facilities. The breadth of service offerings include visiting nursing, palliative care, enterostomal therapy, IV therapy, foot care clinics, adult day away and Alzheimer respite and enrichment programs. Estimated cumulative service stats for the 1992-93 fiscal year are expected to exceed 136,000 client contacts or visits

VON, Simcoe county, employs a multidisciplinary staff: registered nurses; registered nursing assistants; home support or respite care works, who would be health care aides or homemakers; and a recreational therapist. Each care provider works to assess client or community needs and each develops his or her plan of care in partnership with the client

VON is moving to an expanded role for registered nurses in both primary and secondary care. Nurses have a key role in long-term care both in facilities and in the community. The nurse focuses on individual and family response to illness and disability in long-term care, and plays a key role in health promotion and disease prevention. Nurses are well equipped to respond to the diversified needs of the long-term care client. Across the province registered nursing assistants are assuming an expanded role with less complex stable cases still involving skilled nursing intervention, and home support workers are providing personal care under the supervision of a health professional.

As a key stakeholder in community health and longterm care service delivery, as a trusted and credible client advocate and as an organization governed by a voluntary board representative of the Simcoe county catchment area, VON is in a position to ascertain the health care service needs of and hear concerns expressed by the members of the community it serves.

It is from this perspective that I address the following issues specific to the proposed amendment to Bill 101. The seven issues will be: vision, planning, funding or cost containment, quality management, allocation of resources, respite services and, finally, placement coordinators and coordination.

With respect to the vision of Bill 101, Bill 101 is an incremental improvement in empowering the consumer in that it does allow for direct funding grants to the physically challenged. It starts to standardize legislation for long-term care facilities. It ensures consumer access to key information regarding facility services, care accommodation and consumer knowledge of the plan of care. Finally, it allows for an appeal process regarding eligibility for service.

VON most certainly supports these incremental improvements and strongly recommends (1) that these changes be expanded to include similar requirements for chronic care beds or facilities and requirements for residents' councils in all long-term care facilities; (2) that consumers have a choice of whether to receive needed services in a facility or community setting within an envelope of available resources; and (3) that the importance of and provision for service sensitive to cultural, linguistic and racial equity be factored therein.

With respect to planning, it's imperative that planning responsibilities—provincial, regional and local—be clearly defined. Provincial responsibilities could include the definition of core programs that would be available across the province such as foot care, emergency respite services, health education and supportive counselling for care givers; and the definition of a quality management framework including standards, outcomes and reporting requirements.

Regional responsibilities could include specialized service planning such as specialized rehabilitation resources. Local planning could include the continuum of care from health promotion through rehabilitation to chronic level care in the home, community or facility. VON believes that the decision-making authority should be close to all the people. This philosophy is supported by the provincial government and notably by Simcoe county DHC. VON supports the lead role for local planning being assigned to the expanded DHC. This is in fact a reality in my county.

Services to our seniors and disabled require discussion as well. We must be mindful of the importance of provision of a continuum of long-term care services. Some individuals may require only short-term care in a nursing home or chronic care facility, and with appropriate intervention may be able to return to home-based care with supportive services. Both the consumer and the service provider have the responsibility of ensuring that appropriate planning is done to achieve essentially a seamless service delivery.

While VON recognizes the complexity of the longterm care system, we believe that moving ahead with implementation of certain areas before the entire policy framework is debated may further fragment the system. The government, in moving ahead on Bill 101, has sent a clear message that it is still more interested in institutional care rather than developing health promotion and community care options.

With respect to item 3, funding/cost containment, today in Ontario the resources allocated to institutional care—that is, chronic beds, extended care beds and residential beds—far exceed the resources allocated to community and in-home services.

The legislation promotes fiscal accountability by a control of resource utilization rather than on measures for resource outcome. For example, there will be controls as to the number and type of beds, as well as associated costs, rather than evaluating the benefit of facility versus other types of care from a systemic and a consumer perspective.

While a payment system has been identified based on consumer acuity, VON believes that this is in fact an incentive for illness and not for wellness, as intended. Funding formulas are needed that will address the full range of consumer need and care provision, rather than acuity only. Clearly, the funding formulas lack incentives for discharge from institutional care back to the community-based care and lack incentives for rehabilitation to other levels of care.

Although it is recognized that cost-effective service provision is essential, hence the move to the regionalization of specialty services, the geographic realities and uniqueness of each area must be considered. This might involve such innovative delivery concepts as travelling or mobile units, a concept currently under consideration at VON Simcoe due to the county's large rural population.

With respect to quality management, which is item 4, one cannot speak of service delivery without stressing the importance of government assurance as to outcome and quality of same. Standards which would likely be developed at the provincial level would serve to promote a high level of accountability. Development and implementation of standards should be encouraged in conjunction with consumers, government, professionals and agencies involved in the delivery of the service.

VON branches across Canada fully endorse and, I am proud to say, actively take a quality management approach to care. This approach promotes consumer choice and empowerment through client or customer involvement in the evaluative process of programs and services that are provided to and for them.

Bill 101 appears to promote a control or regulatory model rather than that of quality management. Inspection, in fact, has been shown to promote a lack of trust in quality care from both the provider and the consumer perspective. Empowering consumers in a quality management approach strives to ensure that the right services are provided at the right time in the right place by the right provider. VON strongly recommends that the government consider the concepts of quality improvement to ensure high service standard and consumer satisfaction.

With respect to the allocation of resources, at a time when the government is considering the need for flexible funding and service delivery models—for example, capitation or the multiservice agencies etc—the government would be well advised to consider the possibility of multiple funding options for long-term care facility beds. VON does agree in principle that the current funding model of per diem funding is a disincentive to caring for residents with complex needs and intensive resource requirements.

VON suggests that the development of comprehensive multiservice agencies by VON and other community agencies funded by capitation may significantly reduce the bed requirements by providing more comprehensive and potentially cost-effective options in the home.

Furthermore, prior to expanding facility services, other community-based options, such as the utilization of community-based services and facilities, should be considered; that is, active nursing skills and specialty consultation teams, should be considered as part of the funding options. A VON nurse trained in infusion therapy, for example, could provide such services to long-term care facilities that do not have frequent enough requirements for infusion to make the in-house team cost-effective.

With respect to respite services, it is acknowledged that family care givers form an integral component in the continuum of service providers. Up to 90% of the care and support received by long-term clients who live at home is given by family and friends. In order for individuals to be secure receiving community-based services, there is a need to ensure the availability of needed services, on an ongoing basis, through committed and ongoing funding. That is to

say that people who receive long-term care must be able to count on the ongoing availability of the core services, such as community support services, health and personal care and respite services. The services must continue to be available to individuals and families irrespective of their degree of illness and disability. Otherwise, individuals and families will opt for the perceived security of a facility-based service.

While Bill 101 does include a provision for short-stay accommodation, it fails to recognize the community-based respite service option. VON Simcoe county currently provides an Alzheimer respite and enrichment program which stresses care giver support, counselling and education.

With respect to item 7, placement coordination, VON supports the concept of expanding placement coordination and in fact currently administers eight placement coordinators province-wide. As this is recognized as a service need in Simcoe county, VON is considering making application to administer same.

Serving consumers through a centralized, independent and objective placement service will assist to ensure equal and equitable access to both information and placement. VON is pleased to acknowledge that the regulations allow for an appeal process regarding eligibility for service.

Once again, the concern centres around the lack of consumer control over location of sources in the expanded role of placement coordination. We recommend compelling the coordinators to ascertain and provide the consumer's choice of service location.

In conclusion, VON wishes to emphasize our continued interest in and support for long-term care reform and to acknowledge and formally thank the government for utilizing the consultation process so consistently. VON looks forward to working with our partners, consumers, service coordinating agencies and government in planning and implementing an enhanced health care system which will provide a quality continuum of care within available, albeit scarce, resources. Thank you once again for providing me the opportunity to speak on behalf of VON Simcoe County, and I will at this time be pleased to answer any questions that the panel may have.

The Chair: Thank you very much for your submission. As you are aware, I think, and as we've noted, we've had many submissions from the VON.

Ms Miles: I am aware of that.

The Chair: The one thing I know I can say without fear of contradiction is that they have all been very thorough and of a high quality, and we're very glad that you were able to be with us today. Because of some time problems, we're only going to be able to have two questions, and I think, in fairness, those will go to the Simcoe county representatives. We'll begin with Mr Wessenger.

Mr Wessenger: Thank you very much for your presentation. As usual, the presentations of the VON are very thoughtful and comprehensive, and I certainly appreciate them.

First of all, I'd just like to make a comment on your reference to respite care in the community. I'd like to assure you that it is a preference to provide respite care within the

community, and it's really to provide both options. The reason it isn't in this bill, of course, is because this is not relating to the community care aspect of the long-term care policy but is relating only to the institutional aspect.

I have one short question. You indicate that you're concerned about the disincentive for community care or the incentive for more intensive care in facilities, and I'm wondering if you have any more specific suggestions on how you might provide incentives with respect to the community care aspect; as you say, to encourage people, if they are able, to move back into the community.

Ms Miles: I think it's connected very strongly to ensuring that there's community support, and that obviously is the focus that VON would always take.

Mr Wessenger: So to ensure that those services are available in the community is really the incentive you're looking for.

Ms Miles: That's right. Absolutely.

Mr Jim Wilson: From Simcoe Centre to Simcoe West. Thank you, Chair, for exercising your well-learned control of this committee and allowing Simcoe county reps this opportunity, although I'd be happy to share Ms Miles's expertise with any member of the committee who might have a question.

Ms Miles, thank you for coming down today and sharing your experience with us and driving home the points that are important concerns on behalf of the VON. I want to give you an opportunity, though, to give the lay of the land, as it were, to members of the committee who are not from Simcoe county. You mention on page 7 of your brief that the government is moving ahead on Bill 101, and it's been interpreted that perhaps that's sending a message that it's more concerned with institutional care than community-based services. What I gather from those comments is that really it's a question of priorities, that if the government was serious about community-based care—we've already seen a downsizing of hospitals, we've seen a downsizing of that type of institutional care, but we haven't seen the dollars shift to the community-based care. What's the lay of the land in Simcoe county? Are you able to keep up with the demand in terms of providing in-home services?

Ms Miles: To this point in time, we have been able to do that. Where we have experienced some difficulty is that as the demands increase in terms of acuity of care, so do the educational requirements of the staff within the branch. So it is really at that end. It's not so much the inability to provide the service; it is providing the opportunity to have all of our professional staff trained to the degree that they're able to at least satisfy the acuity measure.

Mr Jim Wilson: To your knowledge, has there been movement on behalf of the government to ensure that you'll have the training dollars available to your staff?

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Ms Miles: We have not seen it from a funding perspective, no.

Mr Jim Wilson: Finally, you talk about the fact that respite care should go hand in hand with short-stay accommodation. Do you want to take a moment to explain that?

Because you're right, the bill doesn't speak to a lot of things, and one of them is respite care. Do you want to give us a feel for why that's so important?

Ms Miles: Certainly from our perspective, the success of our Alzheimer respite and enrichment program has been such that the coordinators of the program are of the opinion that there would be a number of persons within the facility structure who could in fact be serviced very well in the home. Because the support to the care giver is just not readily available, the decision has been made by the care giver that placement really ought to be in an institution.

Mr Jim Wilson: So it's perhaps an unnecessary placement.

Ms Miles: In our opinion, certainly at times, yes. It's really based on a care giver's decision more than the actual client's decision.

Mr Jim Wilson: Correct me if I'm wrong. I'm quite aware that in many parts of the county we really don't have any respite care. There are waiting lists, and when you do get it, it's for such a short duration that it really isn't sufficient

Ms Miles: The criterion we utilize in our particular program is that there need be at least a three- to four-hour requirement for our service before we would be going in. I feel definitely very strongly that there is a need for respite and care giver relief on the one- to two-hour basis, not necessarily for extended periods of time.

Mr Jim Wilson: Thank you very much.

The Chair: Thank you very much again for coming before the committee. We appreciate it.

Ms Miles: Thank you, Mr Chairman.

VICTORIAN ORDER OF NURSES, WATERLOO REGION BRANCH

The Chair: Moving from Simcoe county to Waterloo, I would now call the Victorian Order of Nurses from the region of Waterloo. May I also welcome you to the committee.

Before asking you to introduce yourself and begin your presentation, I want to indicate that before you complete your presentation, I'm probably going to have to leave. I just want you to know it's not because of anything you are about to say.

Mr O'Connor: I hope it's nothing we said.

The Chair: No, nothing you said either.

Mrs Elizabeth Allan: I can assure you mine is much shorter. I think you've heard most of it. I don't recognize anyone from Waterloo county here. Is that right?

The Chair: But there's a presence in the room, I'm sure, from Waterloo.

Mr Jim Wilson: Elizabeth Witmer.

Mrs Allan: Good afternoon. It is my pleasure to address the standing committee on social justice. I am Elizabeth Allan. I am the executive director for the Waterloo region Victorian Order of Nurses. I understand you are well-acquainted with VON by now on this committee.

The Chair: Happily so.

Mrs Allan: Good. Most of you end up in the case load at some point in time, so pay close attention.

As you know, we are a not-for-profit voluntary organization. There are 73 branches across Canada, of which in Ontario there are 33 branches. The Waterloo population that the branch serves is about 375,000 people. That takes in numerous small towns and communities in the county. We've been in operation from 1907, and one branch after another amalgamated until eventually they formed, in the 1960s, the Waterloo county. We're located at 5 Manitou Drive in Kitchener, which is about the centre of the county.

Currently, we have a staff of 134 people, consisting of registered nurses, registered nursing assistants, a chartered accountant and clerical workers. In 1992-93, the branch delivered 111,000 home visits. We offer two main programs, visiting nursing and foot care, and within the visiting nursing program we have several qualified specialized nurses.

So the specialties are: palliative care—there is a team that delivers palliative care to the home for dying patients, and 15% of our case load are palliative, dying in their homes, mostly of diseases like cancer; we have a diabetic care specialty; we have 22 foot care clinics in the community; we have an enterostomal therapy clinic nurse; and we have intravenous infusion therapy. Recently, we had a businessman who was too antsy to stay in hospital, and he had his IV with his computer at home and managed beautifully. I would predict that is the future, that many people who are on long-term antibiotics, for a month or whatever, will certainly receive them through an intravenous by the nurse at home and manage beautifully with their work.

The VON board is composed of 13 volunteers from the Waterloo region. Each of the members brings some very specific skills to the board. Some of these board members also sit on other boards in the county. The board's responsibilities include financial, strategic planning and policy development. Since Waterloo VON is a major health provider in our community, it is from this perspective that I bring you these comments on the proposed Bill 101.

The areas of concern in the bill that I will outline include continued fragmentation of the health care system, limited empowerment of the consumer, quality versus inspection control, funding and community agencies.

Continued fragmentation of the system: The current legislation stands alone. It does not envision a totally integrated system of reform. As the bill is currently written, it fragments the long-term care section into sectors dealing with nursing homes and homes for the aged while ignoring the community sector.

The picture presented at this time is not one of a total, redirected, integrated system. The legislation is dealing with some of the parts, and admittedly very important parts. But the largest area, and the place where most of the clients are and should remain, is the community, and this has been omitted, the community part has been omitted. The consumer does not want to deal with parts, and that's what's been the problem. The consumer, when upset or ill, does not understand how to work within the system or to work the system. What he wants is a seamless organization of care where he can move from one sector to another

easily without repeating the same data—that's the tombstone data—and without fear of the unknown. Therefore, the comprehensive multiservice coordinating body is essential for the public to access long-term care. We think it's a good idea.

Recommendation 1: That the legislation be reworked to include the entirety of the long-term care sector and that all segments of long-term care be integrated.

Limited power for the consumer: The bill has tried to empower the consumer. It allows for direct funding grants to the physically challenged; it ensures consumer access to key information regarding facility services, accommodation and knowledge of their care plan; and it allows for an appeal process regarding eligibility for service.

These changes are good. However, they need to be expanded to include a requirement for a residents' council in all long-term care facilities. I saw it in only one aspect of the bill, but it needs to be throughout, for all long-term care facilities. The consumer also needs to be given the choice of the location and the choice of what facility to enter, rather than this being the sole decision of a placement coordinator. I think other speakers have alluded to that.

Recommendation 2: That all consumers have a choice of whether to receive the needed services in a facility or community setting within the envelope of available resources.

Quality versus inspection control: History has demonstrated that control through inspection does not achieve the desired outcome but in fact can produce deviant behaviour due to fear or uncertainty. Therefore, recommendation 3 is that the homes use quality management improvement concepts in order to ensure the highest standards of care for the consumer.

The next issue is funding. The level of payment based on consumer acuity is not an incentive to promote wellness—I repeat, is not an incentive. This system begs the answers to the following questions: Who will monitor the needs of the consumer versus the needs of the nursing home? After all, the home is in business and plans to stay in business. That's its objective. The second question is, what qualifications will the professional who decides the important issue of acuity have, and how does one ensure that wellness is the motivator and the priority for the funding purposes?

So recommendation 4 is that a funding formula be developed that will focus on the consumer's needs and care required, rather than only on acuity.

1550

Community agencies: The community needs have been overlooked in the development of the proposed legislation in terms of the individual needs of the consumer. One of the roles of community agencies and homes is to educate and inform the consumer regarding options available to them in their community; for example, foot care clinics.

VON plays a pivotal role in the delivery of health services in the community and in continually educating the client. Therefore, the integration of community services with nursing homes and homes for the aged is critical in

order to ensure the highest level of care provision to the consumer and to promote a seamless system.

Recommendation 5 is: The proposed legislation must include a linkage of community agencies with the long-term sector to ensure continuous service provision to the consumers.

I thank the committee for this opportunity to speak. I'm glad to see you didn't have to leave, Mr Beer, and I'll be pleased to answer any of your questions.

The Chair: Thank you very much, both for the presentation and the specific recommendations. We'll move to questioning with Ms O'Neill.

Mrs O'Neill: Thank you very much for coming. It is true that we've had many contacts with the VON across the province. I'd just like to mention to you that it's interesting when you talk about quality versus inspection control, because our last presenter in Kingston began his remarks by saying, "Control, that's a funny word," and I think it is, especially when we're talking about care.

The VON in the Waterloo area, I see from your brief, does not do the placement coordination work for the area.

Mrs Allan: No, we don't. The placement coordination is a separate service and my understanding is that eventually it will come under home care if this bill continues. We don't do it, but we do assessments for them.

Mrs O'Neill: So you're asking a very important question that others have asked: What qualifications and what kind of format will the placement coordination take?

Mrs Allan: It's a lot of power for one person. As I listened to the physician who spoke before me, he clearly said the amount of education required for this person. It's essential that the person be very highly educated. I would not suggest that is the case today and I would say that is a concern.

Mrs O'Neill: Because we've been told over and over through the hearings, by both the parliamentary assistant and ministry staff, that the successful placement coordination agencies that are in existence will somehow be grandfathered or will take up this position. You would like something more in the legislation than that?

Mrs Allan: Yes.

Mrs O'Neill: Could you suggest how you feel your concerns could be allayed in the legislation?

Mrs Allan: I don't think it should be one person. I think that gives tremendous power to one person. That's the way that I read the legislation, that it is one person. It sounds like it's one person per home or one person per institution.

Mrs O'Neill: That's one interpretation. The legislation can be interpreted in many ways, in my opinion.

Mrs Allan: Do you interpret it that it's more than one?

Mrs O'Neill: It could be. A placement coordinator could have many facilities under his guidance.

Mrs Allan: By one person?

Mrs O'Neill: It could be one; it could be a group; it could be an agency.

Mrs Allan: I see an agency, but I see one person. That's far too much power. I see that it doesn't give the client the choice. I don't understand the legislation. Does that mean if you lived in Waterloo county and that placement coordinator or group said, "No, you don't belong in these, but we have to put you over to London," is that a possibility? What happens to the family? What happens to the people who have to visit and care for that person?

Mrs O'Neill: We haven't been able to get a definition of what the community would be either. Both of those things are concerns. I'm glad you brought them forward again and I think that the more repetitive that particular concern becomes—the concerns also about your community health component in this bill being lacking. We've been told the bill will be replaced by another piece of legislation that will include the community component. That is also something where we have to take a leap of faith. I'm glad you also brought up the residents' councils, because again, I feel they should be in all parts of the legislation, not just one, as you do.

Mrs Allan: Exactly. The way the bill is written now, the client has to go and say to someone, "I would like to know what my care is." Most clients will not do that. Most clients are reticent to do that, but if there was a council of their own peers, they would quickly say, "I'm not satisfied, and how do I find this out?"

You have to realize the level of education in that generation. Some of them are very timid and they just won't ask. They might sense that something's wrong but they just won't ask it. I suppose that's where they really need an advocate and the advocate would be this council.

Mrs O'Neill: Thank you for bringing your concerns forward.

Mrs Allan: Thank you. I enjoyed meeting the committee and addressing you.

The Acting Chair (Mrs Joan M. Fawcett): You're not finished yet.

Mrs Allan: Oh, I'm sorry. I'm trying to rush you.

The Acting Chair: Mr Wilson is next, please.

Mr Jim Wilson: I'll just ask you a very quick question. You talk on page 3 about the importance of the comprehensive multiservice coordinating body. You also mention prior to that that we're doing a lot of this legislation sort of in a void. We don't have the full picture of what long-term care really is going to look like in the end.

Given that, I'd be very interested to know, in 30 words or less, if you can do it, what you think the multiservice coordinating agency's going to look like and if all the partners will be in there. Because it's a term that gets thrown around. Everybody's supportive of it but nobody can tell me what it is exactly. They've all got little different views of it, and I really would like to challenge the government to give us the full picture on what it is.

Mr White: In 30 words or less.

Mr Randy R. Hope (Chatham-Kent): Give her a little bit longer time. Most people can't even answer the questions.

Mr Jim Wilson: Be fair; this is a fair question.

The Acting Chair: Order, please. Could I have the witness answer the question?

Mrs Allan: What do I see it looking like? It's going to be very large and quite unwieldy. If the board has all the players or a number of the players on it from the various community agencies, it's going to have difficulty, I would say, managing, but I understand the goal is to save money.

Some communities have a lot of this in place already. Waterloo is one community that has many of these factors in place, but a northern community that wouldn't, it will be difficult, and I really don't know how they would do it. I can see what would happen in Waterloo county. It would come to the region. It seems logical.

Mr Jim Wilson: I appreciate your comments because in answering the question, a difficult question at that, you do highlight some of the problems and some of the things going through our minds as legislators in putting this together, because we're also at a pivotal point, I think, in the province with DHCs.

Mrs Allan: Yes, that's right, you are. What do we do with them?

Mr Jim Wilson: And looking at what policy direction the government's going to take with the DHCs in the future.

Mrs Allan: Exactly.

Mr O'Connor: I guess that little discussion that was started there, we really don't know, I guess, at this point in time, because if we take a look at each community, it's all going to look a little bit different. Because if you take a look at, perhaps, a district health council that might be focused around southern Ontario and compare that to one that perhaps represents more of a rural area, it's going to look different.

So of course the comprehensive multiservice coordinating body is going to look different in every area, and of course when that does happen, then some of the people we're going to go see are the VON, because we're going to take its expertise.

You started off by commenting that everybody's going to see, perhaps, a VON at one time or another during their lifetime.

Mrs Allan: I would think so.

Mr O'Connor: I know that when my son was born I certainly welcomed the visit that we had by the VON to help us with my son and the care, and as new parents it's always warming to know that you've got a little bit of support in the community. So it was certainly well appreciated, and he's six years old and he's fine.

The question that I'd like to ask, and I guess we heard a little bit of it from the VON presentation before you, is around the residents' council. We've heard different opinions around the residents' council and perhaps you could expand on it and on its effectiveness—should there be some room for community involvement in that and who from the community, perhaps, should be involved, because I think that's all part of the picture and maybe you'd like to expand.

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Mrs Allan: I think that in the community we've been kind of left over to the side. Institutions have been here and long-term care facilities here, and it's just very recently that they've started to include the community. District health councils have started to say, "Let's look at their budgets and invite the community in."

What happens in the institutions greatly affects the community. If you dump and close a bunch of beds in the hospitals, where do you think they're going? They're going out into the community. I do think that the resident councils are necessary in all these facilities, and I do think that they should be made up of consumers and providers. So include the community people as representatives.

I think the VON and other agencies have a lot to contribute, and I think there'll be a lot of education about what's out in the community. Rarely do these people come back to the community. Once you get access into a nursing home, I think I read something recently that less than 3% ever get back to the community. It's not even considered. It should be considered. How do you consider that? It's by education, by putting these people on committees to work with them. Does that help?

Mr O'Connor: You certainly really drove the point home on page 4 when you talked about whether or not the payment is an incentive to promote wellness.

Mrs Allan: Well, is it?

Mr O'Connor: You certainly did drive your point home at that point. I guess it's something that maybe can be looked at if you do have a committee that's going to represent the community as well.

Mrs Allan: That's right; exactly.

Mr O'Connor: Thank you very much for your presentation.

Mrs Allan: Thank you. Anyone else?

The Acting Chair: Just one more. The parliamentary assistant has a clarification.

Mr Wessenger: I'd just like to clarify this whole question of consumer choice again, because it seems to be misunderstood with respect to placement coordination. The role of placement coordination is to enhance consumer choice by providing all the options to the consumer, those in the community and those in facilities. That includes supportive housing options, home care and all the various facilities. Then the consumer will make the choice as to those options.

Mrs Allan: So are you saying that the way the bill is written it won't be the placement coordinator who'll make the choice, that the consumer will? He'll just lay it out?

Mr Wessenger: The consumer will make the choice, yes.

Mrs Allan: Okay. I appreciate that. I'll take that one back. Anything else?

The Acting Chair: Thank you very much for your presentation and for being here.

Mrs Allan: Thank you. I enjoyed it.

IOOF SENIOR CITIZEN HOMES INC

The Acting Chair: The next group is the IOOF Senior Citizen Homes Inc. Would the representative please come forward. I believe we have your presentation in front of us, so if you would identify yourself and begin, please.

Mrs Cindy Trapp: Good afternoon, Madam Chair, members of provincial Parliament, ladies and gentlemen. My name is Cindy Trapp, and I'm the director of finance at the IOOF Senior Citizen Homes. I'd also like to identify some supporters that I have brought with me today, and I'll have them just raise their hands. I have Mrs Marg Roane, who's past president of the Rebekah assembly, a volunteer and a past service provider at our home; Mrs Bea Hall, a resident and long-standing Rebekah; Mrs Pat Athron, a tenant in our seniors' apartments, volunteer and Rebekah; Mrs Irene Adams, a Rebekah, a volunteer and past employee of the home; and Miss Florence Robertson, a resident and nurse by profession. Thank you for the opportunity to speak this afternoon.

Since 1897, the Odd Fellows and Rebekahs of Ontario, a fraternal organization founded on the great principles of serving our fellow man, have sponsored and operated non-profit support services and housing for children, the elderly, the destitute and disadvantaged of this province. The fraternity created a charitable non-profit corporation known as the IOOF Senior Citizen Homes Inc to hold and operate its new and expanded operations in Barrie, Ontario, which includes a 154-bed home for the aged, 20 units of seniors' independent living apartments and a new 80-unit seniors' supportive housing development due for completion in the fall of this year.

Of the fraternity's 28,000 provincial membership, the majority are seniors who have an imminent stake in the future of long-term care and community-based services. The IOOF is very supportive of the government's initiative to restructure the long-term care and community support service system to benefit our current and future elderly.

On behalf of the fraternity, its members and clients, we would like to comment on aspects of Bill 101, impending regulations and guidelines as they specifically relate to the Charitable Institutions Act. We have serious concerns about our ability to provide a sensitive service to our clients while maintaining our unique identity and autonomy.

We believe that the charitable homes for the aged represent the unique and diverse mosaic of Ontario's society. Through our fraternal sponsorship over the past century, we have willingly provided a range of services and supports that have immeasurably benefited our membership and society, as well as greatly reducing the financial impact on the province's social system.

For some 25 years or more, charitable homes and government have enjoyed a partnership of support, respect and trust to the mutual benefit of our elderly consumers, government and sponsoring groups. However, the flavour of Bill 101 does not recognize or respect the important role played by charitable homes in the attainment of the high standards of care enjoyed by our elderly residents. Bill 101 brings into being an adversarial and punitive system which does not support or communicate the mutual working

relationships that have brought non-profit, long-term care to the accepted standards of today.

On the subject of admission eligibility criteria, we are seriously concerned about the increase in the power and authority of the PCSs to the extent that their decisions relating to client assessment and admission may infringe on the legislative accountability and/or the traditional moral responsibilities that facility boards hold on behalf of their sponsoring memberships. Boards must be allowed to govern and define the mission of their organizations.

One of the primary principles of the redirection was to recognize the consumer's right to choice and self-determination. The amending legislation does not communicate this very important right of the consumer, but instead has left the process, if any, to be defined by regulation. To date, the admission criteria appear to be inflexible and do not ensure admission for reasons of social, religious, fraternal, cultural and/or spousal relationships.

Although the rights of religious, cultural and/or ethnic groups may be recognized, we are concerned that the right of our membership to choose the IOOF's facility will be overlooked. Just as each ethnic group enjoys a unique and special cultural lifestyle, so do the members of our fraternity. As a matter of fact, the lives of many of our elderly members have revolved solely around the fraternity, its traditions, services and social affiliations. We are seriously concerned that the rights of our members living within our provincial jurisdiction will not be taken seriously by the placement coordinators and thus will be ignored.

Therefore, just as the rights of choice for religious and ethnic consumers have been specifically recognized and protected, we respectfully request that our fraternal members be given the same recognition within the regulations and guidelines to choose our facility regardless of provincial or regional boundaries. Requests for transfer from fraternal, ethnic and religious consumers to like facilities should be given priority standing under category 2 and not last standing in category 3 as presently suggested. This will be of particular importance to charitable non-profit facilities with fraternal, religious and ethnic affiliations.

The future willingness of these organizations, as well as ours, to raise funds in support of long-term health care will depend directly on their ability to provide services to the sponsoring memberships. We are quite sure that the province would not wish to inherit these institutions along with the increased costs associated with lost donation revenues.

With respect to subsection 9.5(6), this subsection gives the appearance that the facility has no involvement in the decision to admit a client and that grounds for refusal will be few under legislation.

Just as it is important to protect the right to choice by the consumer, each institution must also maintain its inherent right to choose an appropriate client who best suits its unique fraternal, religious and/or ethnic status, physical environment, human resources, skills and socio-case mix.

The draft guidelines would lead us to believe that many new types of care services will be added to the homes for the aged which have historically been provided in acute, rehabilitative and/or chronic care facilities. These might include catheterization, tube-feeding, intravenous medications and therapies such as speech, occupational and physio. Charitable homes for the aged must be given the freedom to choose the extent of services to be provided within their facilities and must not be penalized through legislation for their chosen direction.

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Many charitable non-profit organizations have successfully operated campus-based facilities which include a continuum of services. The continuum of care service should not be interrupted, nor the right of the consumer, having met the eligibility requirements, to be given priority status for admission to the campus institution when a bed is available.

On the subject of the appeals process, we applaud the government for recognizing the need for an appeal process as a means through which consumers can seek an impartial hearing regarding an adverse decision for admission. However, we are distressed in that the legislation does not go far enough. Facilities must be provided with a similar appeal process under legislation to allow an impartial forum in which they may address concerns arising from compliance issues, levels of care assessment, admission criteria, subsidy funding, service issues and other like concerns that would adversely affect their day-to-day operations.

With respect to clause 9.8(2)(a), we suggest that clause 9.8(2)(a) be amended to include "an advocate and/or an agent acting on behalf of the applicant." If the current trend for seniors' long-term care continues, it would not be unusual to have an applicant in his or her late 80s or 90s. Applicants seeking a decision by the appeal board may not have the ability to represent themselves adequately and/or appropriately under the act.

Subsection 9.8(3) allows for a single-person adjudicator to preside at such appeals. We believe strongly that if a sensitive, just decision is to be reached, the quorum of the board should be a minimum of three persons, each from a different discipline, thus ensuring an interdisciplinary approach to the board's rulings.

Quality assurance should be a process through which all the partners in care strive for improvement and excellence. However, we are concerned that defined quality assurance issues will become non-negotiable and inflexible through the inspection process. A quality of care incentive approach would be far more palatable than a regressive quality assurance system which is only used as an enhanced enforcement mechanism. If quality assurance is to be legislated, then the legislation and/or regulations must ensure that the issues identified through the process are positive, supportive, negotiable and not punitive.

With respect to posting of information, section 9.15, we agree that certain information should be available to our residents' families and the public relating to service agreements, legislation, regulations and other such information. However, we do not support the premise that this information must be posted in the main entrance of our facilities. Homes for the aged have long strived to become less institutional in nature and more residential in appearance. Posting of such information in libraries or having

such information available at the business office would better suit our residential environment.

Although the financial information regarding our operations is public, we suggest that the posting of such information may directly result in the unionization of many non-union charitable facilities and also provide an open opportunity for this information to be used by unions to negotiate contracts that are comparable to those in the municipal sector of south-central Ontario.

Unless the province is willing to provide the increased subsidies to allow for such settlements, we strongly suggest that financial information not be publicly posted. Our corporation supports fair wages and benefits for all staff in long-term care, but we do not agree with the unusually high wages and benefits being paid in the municipal sector at the expense of the public purse, which will soon impact on the quality of care to be provided.

Not surprisingly, the dramatic change in admission age has been a direct consequence of increased community services and an inability of our system of support services to keep pace with the growing elderly population. As a result, the institutional sector will continue to overtax facilities' human and financial resources. We believe it will be impossible for the youth of today to fund, through the tax system, the social services of our society within 20 years.

We believe that equitable user fees must be established, based on income testing and asset availability for all non-health-related services provided in institutions. The government should not restrict the potential income to be derived from this approach by arbitrarily setting limits on the number of persons who should pay the full preferred accommodation rate. It would be irresponsible to promote a discriminatory fee structure for similar accommodations when faced with shrinking tax resources and burgeoning provincial debt. When a consumer has the ability to pay for non-health-related services, they should not be provided at society's expense.

Quality of care must not be sacrificed as a tradeoff for cost containment and ease of administration. All costs related to health care must be recognized. We strongly recommend that the funding system incorporate specific quality incentives to institutions; for example, on an institution attaining accreditation.

Financial incentives should be created to increase postacute-care discharge to facilities to decrease free hospitalization and inappropriate stays and to encourage long-term care facility participation. We believe that such incentives would strongly influence agency behaviour and better serve to improve quality of care, access and overall cost containment within the health care system.

The case mix reimbursement system must recognize a labour index where wages and benefits cannot be adjusted downwards. The funding formula must be sensitive to the labour rates of the current collective agreements and increased costs associated with imposed settlements under arbitration.

Staffing levels and ratio guidelines must be developed that focus on outcomes of care and not processes of care. Serious attention should be given to avoiding mandated staffing levels that would restrict facilities from being creative and flexible with fluctuating availability of human

We strongly believe that it is vital for the case mix classification and reimbursement system to be rebased and reweighted annually for the first three years and then every five years thereafter. This approach will be mandatory if we are to better understand the transition to the new system and to respond to changes in the future.

We also believe that the administration should consider letting additional funding dollars flow in 1993 and amend subsidy formulas later. Our concern is that if facilities don't receive additional moneys this year, it has the same effect as a mandatory reduction in services immediately as staffing levels will have to be reduced.

In conclusion, we are on the precipice of a new generation of issues where service delivery to the elderly and the physically and developmentally handicapped require innovative solutions to meet the challenges of heightened public expectations and service needs in a climate of shrinking financial resources.

It is this combination of factors that has created our current chaotic situation for unprecedented demands on our social service and health care system. We are now presented with a window of opportunity to create services that adapt to the multifarious and dynamic environment in which we live. In so doing, we must not lose sight of our primary objectives by obfuscating the issues with increasingly complex solutions and systems.

On behalf of our board of directors, residents and staff, we wish to thank the committee for this opportunity of addressing you here today. I'll be glad to answer any questions.

The Acting Chair: Thank you very much. We appreciate your coming before the committee today and also appreciate the members of your group coming as well. We'll begin the questioning right now with Mr Wilson.

Mr Jim Wilson: Ms Trapp, I want to thank you. Although it's late in our committee hearings, you're one of the few presenters who's talked so much about finances and the ever-increasing burden that our social services are placing on the taxpayers of Ontario. So often governments don't want to talk about that in the open, and they sure don't want to talk about it at committees, because it's politically sensitive stuff. Maybe it's because you're a director of finance that you've given us, I think, a very balanced approach. You've hit a number of issues head on, which politicians don't like to do.

As you talk about in your conclusion, government response to these ideas has been to make everything seem far more difficult than it really is and to try and always respond—and all governments are guilty of this—to citizens by saying, "Well, that's such a complex matter, I don't think we can really discuss it fully today."

Having said that, I want to go back to the bigger question, because it's been raised a lot when it comes to charitable homes for the aged, and that is that I think opposition members, through amendments, and the government, through its own amendments, can do some things with Bill 101 to protect and in fact recognize the cultural and

spiritual needs of residents, and maybe a few others, maybe linguistic and—

Mrs Trapp: And fraternal is our point.

Mr Jim Wilson: Yes. Yours is fraternal; others, it's the same idea. The fund-raisers at Baycrest have worked long and hard, and when they have a family member who needs to get into Baycrest—I don't blame them—they want the family member to get into Baycrest. They've worked hard to raise money and sit on the board of governors and that sort of thing. I think it's human nature and I don't blame anyone for it. I'm just not sure how we can do it, unless we put a provision in the bill that says that the sponsors of the home have a priority access.

We've just spent the afternoon talking about veterans' affairs and the worry of the Canadian Legion that, even though they've got some agreements in place with the federal government and the provincial government, there's a dispute going on whether or not their priority access will even be secured with the passage of this legislation.

So I guess what I'm going to ask you to try to get a feel for things is, what would be the frequency of others outside of the fraternity actually applying to your home? That would give us an indication of the need for protection.

Mrs Trapp: There's no doubt that the majority of the residents who live in our home are still from the community which we operate in. I would suggest that 10% to 15% of the residents in our home may also be from our area but may be from outside of our locale and a member of the fraternity.

Mr Jim Wilson: I see. Do you have a waiting list at the home?

Mrs Trapp: We have a waiting list of close to 300 people.

Mr Jim Wilson: And of the 300 the vast majority would be fraternity members?

Mrs Trapp: No. I would say that 10% to 15% would be fraternity members.

Mr Jim Wilson: Is that right? That gives us an indication of what the problem is.

Mrs Trapp: I think we've also addressed that in terms of what category they would be in too. We're moving it up to a category 2 rather than a category 3 in terms of—

Mr Jim Wilson: Except that the eligibility criteria are very medically based and don't really take that into account, other than I think we are going to do something in terms—I hope anyway—of ensuring that consumer choice is given a higher rating than it currently is, and perhaps that will go a long way.

Mrs Trapp: The people I've brought with me today could speak to that because that is definitely their preference, if they are a member of that fraternity, to have that choice recognized.

Mr Jim Wilson: Sure. I understand that and to a great extent I agree with that.

Mr Wessenger: Thank you very much for your presentation. I'm certainly very familiar with the IOOF home

and also with the Rebekahs and Odd Fellows because as in the past, as you—

Mrs Trapp: Everybody noticed the friendly face across the room.

Mr Wessenger: I certainly appreciate the leadership that you've taken, particularly for your latest venture, the supportive housing project, because that does provide a great addition to the community in providing for that choice.

For instance, the spousal situation I think can be very much accommodated by your having the supportive housing unit there along with the long-term care facility. It gives a choice for spouses, which I think is commendable and something we need more of in these types of new facilities. I would also like to welcome the residents here from the IOOF home.

I just have a couple of comments. First of all, you mentioned the whole question of consumer choice. Yesterday we did announce that we're going to bring an amendment forward to the bill that will require the placement coordinator to recognize the preferences of the applicant, particularly those relating to cultural, linguistic, ethnic and spiritual aspects.

Mrs Trapp: So fraternal will be included in that?

Mr Wessenger: I think cultural would include that aspect.

Mrs Trapp: I'll be encouraged to take that back.

Mr Wessenger: Cultural is a pretty broad concept and I think it would include that.

Secondly, you make a reference with respect to the limits on those who pay the full preferred accommodation rate. I'd just like to indicate that those limits are under review at the moment.

The other thing you mentioned was the review of the case-mix classification. You asked it to be done annually for the first three years. I'd like to assure you of the intention that it be done annually, period, not just for the first three years, because we certainly want to make sure that the funding keeps in line with the—

Interjection.

Mr Wessenger: Staff wants to clarify.

Mr Quirt: I'd just like to clarify that the resident classification exercise to determine care requirements in each facility would be done annually. But I think what you're referring to in your brief is a provider activity study to make sure that the seven categories appropriately reflect the differences in actual service consumption. For example, does a client who scores as a G really require 5.3 times this much funding for nursing and personal care as a client who scores as an A, or should it be seven times as much or four times as much?

We will be doing that review this fall and we will be doing it at regular intervals. We'll be doing it at least every five years. But we want to see how the results come out this fall to see how far off they are from the assumptions in the instrument now. If they're way off, then perhaps we'll have to do it again next year to make sure that we keep more current. But it is our intention to do that on a regular

basis to make sure that it's a fair measurement of the actual care requirements of residents.

Mrs Trapp: Thank you very much for that clarification.

Mrs O'Neill: I really thank you for this brief, and I guess I would ask you, rather than the parliamentary assistant, whether you think the term "cultural" includes fraternal.

Mrs Trapp: I question that. We think that is a unique definition, and so I hope that, yes, it would be included in cultural. But by us bringing that point up, it hasn't been clear to us that it recognizes fraternal as well.

Mrs O'Neill: Maybe we should consider very strongly adding it.

Mrs Trapp: That would be our recommendation of a specific definition.

Mrs O'Neill: You brought forward several things, and I concur with my colleague about the financial highlights. Not many presenters have talked about the pressures of the collective agreements that are in existence right now that are still going to be in existence, and the only cut then that could be made is service in many cases.

Mrs Trapp: That's correct.

Mrs O'Neill: I think you've also highlighted the financial incentives that should be built into the system to have people move forward when their care is to be less intense or less heavy, as we call it, and I think that's another very good point.

The one I wanted to ask you the question about is where you really began, because we haven't had too many people suggest it to us. I have had an opportunity to ask one other group. You feel that the IOOF's ability to govern or the governance structure is somehow going to be threatened, that the mission statement is not necessarily going to be possible to meet. Would you like to say a little bit more about why you feel that way about Bill 101?

Mrs Trapp: Our concern is that if the placement coordination service agency has the authority to say who is coming into our home, we feel that we want to have some authority over the levels of service that we provide and how we provide that service; that forms part of what our board does and the role that it performs. So, for example, for the types of therapies—occupational, physical, social—we will have to have the staffing levels appropriate to meet those levels of care. If the dollars aren't there funding-wise for us to hire the additional staff to provide those services, we feel that we should have control over what our organization offers in terms of the facilities, both residential and nursing.

Mrs O'Neill: I think this is one of the big difficulties with organizations and facilities such as yours: They feel their strengths and the traditions that have been built will somehow not be recognized, built upon and used.

Mrs Trapp: That's correct.

Mrs O'Neill: I hope somehow we can get some wording into the bill that will guarantee that your mission and your decision-making is protected.

Mrs Trapp: That's exactly what we're looking for. We're proud of the facility that we run. I think our resi-

dents would confirm that it is a home, and we hope to be able to continue in that vein.

The Acting Chair: Thank you very much for coming before the committee. We appreciate your time.

Mrs Trapp: Thank you very much for the opportunity.

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DON MILLS FOUNDATION FOR SENIOR CITIZENS, INC.

The Acting Chair: Now if the representatives of the Don Mills Foundation for Senior Citizens, Inc, would come forward, please. Welcome to the committee. Take a seat there, please. We have a copy of your brief, so if you would like to introduce yourselves and proceed.

Mr Joseph Bogdan: Thank you, Madam Chair. My name is Joseph Bogdan. I'm a member of the board of directors of the Don Mills Foundation for Senior Citizens, Inc. I would just like to briefly introduce you to our foundation.

We are a not-for-profit community organization composed of volunteers and professional staff. We are committed to all aspects of care for seniors in the community and we offer a broad range of services and a commitment to a continuum of care.

The Don Mills Foundation was formed in 1969. We opened a 136-bed home for the aged in that year. Then in 1976 we opened Taylor Place, a senior adult centre which today serves an annual membership of approximately 1,100 people and, in addition, provides services to 800 seniors in the community through home support services, a frail elderly day program and an Alzheimer's day program.

The foundation is, I think, to use a cliché now, proactive rather than reactive. We have been in the forefront of a number of programs for seniors even before they were allocated for government funding. We basically have that as our mandate through our board and staff at this time.

I would like to introduce to you Bill Krever, who is our CEO. I would like Bill to take you briefly through our presentation.

Mr Bill Krever: Again, let me just restate that it's a pleasure to be before the committee this afternoon to talk about Bill 101. We certainly appreciate this opportunity.

There are really four areas that I'd like to briefly touch on about Bill 101 that we're concerned about, but before I do that, I just want to state that one of the differences about the Don Mills Foundation is that not only do we represent a long-term care facility or home for the aged, but we also have many other elements of the long-term care system, including home support services, community services and an elderly persons' centre. I think that's a little different perspective that we're coming from today.

In terms of the four areas I wanted to briefly touch on, the first is access to long-term care facilities, the second is the funding formula, the third is incentives and motivation for local governance and the fourth is conditions of admissions.

In terms of access to long-term care facilities, certainly the concept of centralized or single-point access is a key component of long-term care reform, and it's a principle that's strongly supported by the Don Mills Foundation. The placement coordination model, as proposed in Bill 101, however, fails to recognize the strong role of multi-service agencies. Certainly that has changed somewhat over the last couple of months with the introduction of the comprehensive multiservice agencies, but we're still not quite aware of exactly the definition of those agencies. That is one of our strengths in the Don Mills community.

Just to give you an example, many of the admissions to Thompson House home for the aged come through our network of community support services. In these cases, applicants are already linked with a case manager or a placement coordinator through our agency and the admission process, and the related emotional stress for applicants and their family members is minimized. With the proposed new placement coordination system, the admission process could become more stressful for the applicant, not to mention more expensive and unnecessary for the long-term care system.

Also, with the growing demand for long-term care facilities and the current waiting lists for facilities, it's important to maximize all of the existing long-term care beds, and the effect of an efficient processing of new admissions is an important business component of any successful long-term care facility. The addition of a placement coordination service could be counterproductive in terms of maximizing the use of all existing beds. Certainly the foundation is committed to maximizing the use of all our programs and services along with, at the same time, respecting and enhancing the dignity and independence of the seniors we serve.

In terms of the funding formula, again the principle of level-of-care funding is strongly supported by the Don Mills Foundation and is a major improvement to the longterm care system as we see it. However, the lack of funding for all areas of the system and for levels of care is eroding the quality of long-term care and is drastically reducing the innovative and creative nature of most nonprofit service providers. Further, the concept of level-ofcare funding does not work unless the established funding for care is adequate compared to the actual cost of providing care. As we have experienced with the existing funding arrangement for residential and extended-care beds, and also in the community for home support services and Alzheimer programs, the theoretical funding formulas are not effective if the key and controlling factor is an annual provincial funding allocation process.

Also, the proposed resident copayment scheme is a major concern for the foundation and represents a dramatic loss of income from resident rents. The concept of incomeonly testing rather than the current income and asset testing will cost the long-term care facilities and the province millions of dollars. This is at a time when funds are drastically needed in all areas of the long-term care sector and any removal of funds from the system will put extra pressure on government funding.

Also, the proposed funding formula restricts the ability of long-term care facilities to establish special resident services based on fee-for-service, and also the provision of private rooms is restricted and the rents that facilities can charge for private rooms.

In terms of incentives and motivation for local governance, the foundation has been a leader in the field of longterm care services for more than 25 years, and it's through the efforts of a community-based, voluntary board of directors that we've implemented a wide range of vital services.

Bill 101 greatly increases the amount of government involvement through inspections and a sanctioning process. Unfortunately, this involvement does not necessarily correspond to an increase in quality of service and merely serves as a disincentive for existing governing bodies.

Also, quality management or quality assurance is an important planning and monitoring process within the long-term care sector, and this type of approach has been implemented by many non-profit homes for the aged in Ontario on a voluntary basis. As well, a number of homes for the aged have received accreditation through the Canadian Council on Health Facilities Accreditation, and many other homes for the aged have adopted the principles of accreditation on a voluntary basis. This commitment to quality management demonstrates the integrity and professionalism of the not-for-profit sector. The best approach, we feel, to quality management is through commitment and ownership on behalf of the governing body and not through provincial regulations.

Finally, in terms of conditions of admissions, Thompson House home for the aged currently serves 136 residents. We've estimated that about 90% of our residents would meet the proposed admission criteria. The remaining 10% of our residents would not likely be approved for admission under the new structure. It must be stressed that these residents have chosen Thompson House as their home and have made an important decision to move into a long-term care facility. It is apparent that while they do not meet the proposed criteria, these residents require the services of Thompson House and are not capable of or willing to live independently in the community. While we recognize that current residents will not be affected by the proposed admission criteria, we also realize that future applicants who do not meet the criteria will ultimately be denied admission to a long-term care facility.

I think one of the positive aspects of the current funding structure of residential and extended-care beds has led to the development of a mixture of residents ranging from those individuals who need very little nursing care and are very active and mobile to those individuals who require heavy nursing care and have severe physical or cognitive limitations. This mixture has added somewhat to the atmosphere of many long-term care facilities and has created, we feel, a more positive image of aging and has developed a certain peer support component among residents. With the new admission criteria, some of this resident mix will be lost.

In conclusion, again we would like to stress that the foundation is very supportive of many of the principles contained in the long-term care reform. Through our 25 years of experience in providing services in all areas of the long-term care spectrum, we do recognize the need to develop a more integrated and responsive system.

One of the key elements that has enabled the foundation to be successful over the past 25 years is the fact that we do represent all major areas of the long-term care spectrum.

We recommend to the standing committee that all elements of the long-term-care spectrum be considered within Bill 101, and not only the narrow spectrum that deals with homes for the aged.

Again, we'd like to thank the committee for the opportunity to appear this afternoon, and we'd be glad to answer any questions.

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The Acting Chair: Thank you very much for your presentation.

Mr Wessenger: I'd just like to ask you one question. You indicate that there'll be a great deal of revenue lost as a result of not having an asset test with respect to copayment provisions. Do you have any range of estimates of how much of the revenue you feel would be lost to homes for the aged in Ontario? Any percentage indications on that?

Mr Krever: Certainly we haven't done that type of analysis for our own facility, because we understand that any revenue that's lost now will be picked up by the ministry in terms of the funding formula. Just to give you an example, on an individual basis, I believe the daily rate now for residential care is about \$52 a day, in that area. That will go down to, I think, \$36 or \$38 a day, so per day that will be the loss. I have heard estimates for the province— and I don't know the extent of the reality of this—that in the area of \$20 million could be lost through this.

Mr Wessenger: I'll ask ministry staff to clarify on that issue.

Mr Quirt: The figure you just mentioned is quite close to the real figure. It's approximately \$20 million that residential care residents pay now that they will not have to pay under the new income-tested copayment.

Mrs Sullivan: Then could I just ask the parliamentary assistant why the government has indicated it will no longer include the asset test, when in fact that \$20 million could be used elsewhere in the system rather than basically to supplement people who do have resources? These are 20 million taxpayer dollars.

Mr Wessenger: Certainly it's been a policy decision that unfairness is created in requiring asset contribution. The case in particular of the spouse in the matrimonial home is one where you would not want to look at an asset situation, or perhaps an asset which is non-liquid, which would again create a great difficulty, and also to respect the dignity—we've certainly heard from consumer groups that very much advocated that assets not be included in the obligation to make copayments.

Mrs Sullivan: I think it's a remarkable public policy decision.

Mr Hope: Are you for it?

Mrs Sullivan: No. I'm very interested in the discussion you have about your own residents, where you indicate that about 10% of your residents would not meet the criterion included in the manual for admission. How many of your residents would have preplanned their stays in your facility?

Mr Krever: I would think most would have. We have a centralized process somewhat similar to what will be

done with the placement coordination system. I would say most of the admissions now go through about a three- to four-month period of admission, so it is planned. There are probably 10% or 20% that are emergency-type admissions either coming from hospitals or through sudden illness, but most would be planned, and most also are planned through our home support services. We may have members of Taylor Place who have planned five years ahead that when the time comes, they would like Thompson House to be the long-term care facility they live in.

Mrs Sullivan: If and when this bill passes and the placement coordination system is put into place, would you indicate your interest in serving as a placement coordinator?

Mr Krever: Certainly that would be something we would be interested in. We are already doing those functions now. We have those resources on staff. Until we see the final definition of the comprehensive multiservice organization, it's hard to know whether we would fit that, but I would think that along those lines, we would see ourselves fitting into that model.

Part of our concern is that homes for the aged have been doing the admissions already and have the resources and the staff now to do all of the admissions, and with Bill 101 we're going to have to hire staff province-wide to do all of that work again. We're almost duplicating those resources, so that is a concern.

Mrs Sullivan: Have you had any indication that the ministry views placement coordination from the providers as a conflict of interest?

Mr Krever: Not really, to any extent. We haven't been that involved in those discussions. Personally, we haven't seen it as a conflict of interest in our role, I think because we are multiservice and part of our placement service is also to look at other facilities, so that if Thompson House is not the appropriate facility, our placement coordinators would work with other facilities.

Mr Jim Wilson: Thank you for your presentation. Since you are the second-last presentation, I want to make a comment on something you touched upon in your presentation; that's with regard once again to the government's policy decision to simply do an income test and ignore assets. You should know and be aware that this was the government that used to talk about corporate welfare bums, I recall, having to run a campaign against them two and a half years ago.

I just want to show you the inconsistency in their logic. CUPE earlier this week talked about nursing home operators getting rich on the depreciation of their assets. Now this government that hates depreciation of assets and write-offs thereto is ignoring them altogether. Frankly, I think they just don't understand. It's sad, is about all I can say. I don't know why any government in this day and age would want to forfeit \$20-million worth of revenue, when all indications to this committee have been that it's badly needed out there. I'm sure the Treasurer would have had something to say about that.

The Acting Chair: I know there's a question coming soon.

Mr Jim Wilson: Well, it's free speech.

I just have one quick question with regard to social admissions, because we are in the process of drafting amendments on whether we should include that in the admission criteria and allow for social admissions. You mentioned in your brief that about 10% might be social admissions. You see that as a positive, I gather, in terms of giving you a mix. Does the proposed funding formula give you an incentive to keep social admissions?

Mr Krever: Not really. When we look at admissions, we look at each individual admission through the placement coordination service, so it's based on the need of the applicant. We do look first at community alternatives, but what we find is that there are some people who need a long-term care facility even though they don't need all of the nursing services. So for us that really isn't a concern.

Also, with level-of-care funding obviously there would be an incentive if you were trying to keep a staff complement to match a higher level of care. That's never been a concern for the foundation.

I think more of a concern for us is that Thompson House is really a community for the residents, that is the community they live in, and I think having a mixture of residents is helpful. Also, it certainly affects the appearance of the home. In Thompson House, the second floor, which is our main floor, is basically the residential area; it's free of nursing stations at this point and it's a very different environment. I think it's a very positive look when you first come into Thompson House. With this reform, we would have to look at renovating that area, putting in nursing stations, doing many modifications, and of course we would also look to the government for capital funding to do that.

More importantly, for people coming in from the community to look at Thompson House for the first time, it would give a very different impression of the facility if all you're seeing is heavy levels of care. I think even for the applicants themselves it would give a different impression. I think the perception of many applicants as to their own level of care is often very different from the reality, and I think to be confronted with that in all areas of the home would be a negative perception.

The Acting Chair: Thank you very much gentlemen for your presentation. We appreciate it, and certainly you've added a unique insight into your facilities.

ASSOCIATION OF PLACEMENT COORDINATION SERVICES OF ONTARIO

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The Acting Chair: Next, and the last presenter of the hearings, is the Association of Placement Coordination Services. Is it safe to say we've left the best to the last?

Mrs Joyce Caygill: Oh, that's a wonderful thought.

The Acting Chair: We welcome you to the committee. Would you identify yourself and then make your presentation, please.

Mrs Caygill: Thanks very much. I'm Joyce Caygill. I'm president of the Association of Placement Coordination Services of Ontario and I'm also the director of the placement coordination service in Hamilton-Wentworth.

I know you're all tired, or at least if you're not, you should be, so I'm not going to keep you very long, but I do hope that if you have questions, you'll pose them to me.

The full text of our association response is contained in the February 11, 1993, document, with which I believe you have already been supplied. Today, I just handed out some notes that I'm going to speak to now.

You'll note in that official response that our major emphases are upon our support for the streamlining of the current pieces of legislation and reducing the fragmentation in service delivery which results from so many disparate acts and regulations. But we strongly support the intent of the provincial government to provide equitable care to those who require it and to be as judicious in the use of the tax base as possible.

We support the plan to provide those disabled adults who wish to purchase their own services with funding to do so. However, we regret the continued omission of special reference to those with cognitive impairments and those whose care needs make them difficult to place.

We support the concept of an appeal procedure. In fact, in our 1990 response to the Strategies for Change document, we said, "An appeal procedure should be fundamental to the development of any program." In our response to the Redirection of Long-Term Care document of 1992, we said, "It is necessary to have a decision review or appeal committee responsible to consider the overall service of the SCA." At that time we were expecting the home care and the PCS programs to be merged in a service coordinating agency. So now I guess you could call it CMSA.

In our 1993 response to Bill 101 we say, "APCSO members recognize that a consumer appeal procedure to review determination of eligibility is essential."

I agreed with the earlier comment when the lady from the IOOF said that individuals should be able to be represented in any appeal by their family members, because it's our experience that a great many of these people who might be appealing are not able to do it on their own behalf. So really, they must have either a family, a friend or somebody representing their interests. Perhaps when the advocacy bill comes in, that would be an appropriate road for an advocate. I don't know.

Similarly, we have been ardent supporters of the concept of choice, both for the prospective resident and for the care provider agency. In 1990 we said, "There should be profound respect for the autonomy and independence of the individual and equal respect for the dignity and decision-making capacity within the family unit." In 1992, we quoted our mission statement, and the second item in our mission statement is that we "recognize the individual right to freedom of choice and quality of life." Further in that document we stated, "We expect that clients and care givers will not only be involved in the decision-making, but that they will assume some of the responsibility for developing service plans." In other words, they're integrally involved in everything that involves that individual.

We believe very strongly, and we've written on this many times, that it's important that persons be treated with compassion. Those who apply for placement and back out at the last minute should not be penalized because they're cautious or because they're slow to make decisions. They must be allowed to make decisions in their own way and in their own time

Similarly, those who accept a placement in order to wait for their first choice must continue to have their waiting periods honoured. In other words, if they accept placement somewhere to wait, they must not go to the bottom of the list for their chosen facility. PCS has always been careful that this doesn't happen, and by the way, you know, I suppose, there are 23 PCSs in the province of Ontario, and the one in Hamilton has been in operation for 23 years next month

Incidentally, as to the waiting lists, in those 23 years, I have been going and taking the waiting lists from the institutions at their request and returning to them those people who truly are waiting. We have never found that more than 10% of those who are on the waiting list are actually waiting for placement, because people put their names on in case; they put their names on even though they're inappropriate for that facility; they put their name on at perhaps 16 facilities; they may be dead; they may be placed; they may have changed their minds; they may have left the community. Never once have I taken 300 names from a home and given them back more than 30.

I've emphasized the focus upon choices because I've heard that this is a subject of much concern in long-term care facilities, and the reason I quoted from documents we have produced is so that you know I'm not responding to the comments alone, but that I am giving you our philosophy. Those who have been involved with the PCS over the years know that our credo is choice for the consumer and choice for the receiving facility. We can't do it any other way.

I agree that this isn't mentioned in Bill 101, but our understanding of the legislation is that it is an enabling document only. It's the regulations and the guidelines which accompany it that will spell out the ways in which we can operate, as will the policy and procedures manual for placement coordination. I have spent the entire day with the design team looking at those things, and I can assure you that there isn't one of them who isn't absolutely clear on these particular issues around choice and recognition of the needs of the receiving facility and the uniqueness of the facility. I've said that in the next paragraph.

It's obvious that in some locations choice is based upon availability of facilities and beds, but that in no way prevents consumers and providers from making choices within that context. If the only thing you have in your region is a nursing home and a home for the aged, then at least people can choose between two options, if that's all there is, but they must be able to make a choice.

Certainly, APCSO wouldn't want those facilities which are ethnic- or religion-specific to see their cultures being eroded. We support their concerns, and I supported the two speakers who I heard prior to me. We react appropriately in our present dealings with them and with consumers and we hope to continue to respect them in the future under Bill 101. I would like to suggest to you that we might have a little civil disobedience here, because if you didn't in-

clude that, we would do it anyway, whether you wanted us to or not, because that's the way we feel.

I've attached to your little brief here a copy of a recommendation letter which is in standard use in PCS Hamilton, and I'll tell you how it came about. I went to my support staff and they were typing all these letters. I said, "Just give me the top one, will you?" and I whited out the name on it.

As you will see at the back there, it just so happens that it relates very clearly to choice. It says, "We have reviewed this assessment and suggest 'Type 2' level of care"—type 2, by the way, refers to the Ministry of Health patient care classification by type of care, which was produced in 1975, which we're still using—"specifically, that which is found in a nursing home that will accommodate an O² concentrator and a dialysis regime such as," and we mention three that will accept both the concentrator and a dialysis regime. "Please have the client/family visit the suggested facilities and advise us of their preference. We suggest the client/family maintain contact with the facility of their choice. A copy of the assessment will be forwarded to the chosen facility/ies upon recept of a signed consent form." Then we advise the home care case manager to discuss the nursing home monthly copayments with the family.

You'll see that the printed questions on the bottom there are for the health professional to fill in. In other words, the case manager would go out and say to the client, "What do you think about this suggestion?" say to the family, "What do you think about this suggestion?" and "What does the care provider think about this question?" Then we ask also that they contact us immediately if there's disagreement.

If you look at the other pages, you'll see that there are two sheets there that are what we call consent forms. In Hamilton-Wentworth, we have to deal with a lot of people whose first language is not English and whose level of education may not be high, so we try not to do things in legalese; we try to make it very simple. So we're saying: "We've suggested nursing home placement. Let us know which ones you prefer." Further down, we ask them what kind of accommodation they like and we ask them to complete it and return. We've made it quite clear that we can't release any information until they've given us this consent, and we've also made it quite clear that we are dependent upon their choice.

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Because it's so confusing for people when you have a lot of facilities in a place as large as Hamilton, we've separated the nursing homes and the homes for the aged, because you simply can't expect people to know the difference between the two. We've certainly explained it to them, but then they forget. In the future, I think we can be able to combine all of those into one list, but they still would have their own choice—at least I hope so. They will if we have anything to do with it. I think you can see from this that the copies of consent to release information clearly identify the PCS approach to choices.

I haven't cluttered you with a lot of other information because I think those are the major ones, but I'd be delighted

to answer questions if anyone has any.

The Acting Chair: Thank you very much for your presentation and your slight confession beforehand, in case something—

Mrs Caygill: Yes, I'm sorry about that. I hope nobody holds it against me.

The Acting Chair: Definitely not. The first questioner is Ms O'Neill.

Mrs O'Neill: This is very interesting, because we haven't seen these forms before. I'd like to go to the form.

Mrs Caygill: That's only Hamilton's; everybody has a different one.

Mrs O'Neill: Okay. I'd like to go to the form, if I may. You have suggested that you try to simplify it as best as possible, and you've got the copayment rates there. Would people know what they meant if they got this? Would you have explained before how this could be dealt with? I mean, some of this could be quite frightening.

Mrs Caygill: I draw your attention to the person to whom it's addressed. It says, "To: Case Manager, home care program," so this would not be given to the individual. If it has to go to the individual directly, they have a personal letter that says, "We've reviewed the assessment and we think that your mother would be able to manage very well in such-and-such a place." In other words, it's couched in much better language. This is for the home care case manager to go out and say, "We've talked to PCS and this is what it thinks." So this is advice to the home care manager.

Mrs O'Neill: Having cleared me up on that—and I guess I am tired—

Mrs Caygill: I think it's logical that you would ask that question.

Mrs O'Neill: Where do you see the appeal process—and I presume there may be one in Hamilton; I don't know—as it's built into 101, coming on stream with this kind of a system, which you seem to have worked out over a period of years?

Mrs Caygill: I think that I have to be honest and say that as we do now, we're determining eligibility based on the extended care benefit form, because what we would be doing is saying: "I can see that you would like your mother to go into a nursing home, but quite frankly, she won't meet the eligibility criteria. I think you've got to look at some alternatives." Over the years there have been one or two people who have said, "I still want her in a chronic hospital," or whatever it might be. So we have developed an appeal procedure and what we did, because of course we were just acting locally, was convene a committee of providers of care, both medical and nursing, in those long-term care facilities, presented the case and asked for their opinion. Their opinion was binding as far as we were concerned.

I see a similar type of thing, but with different representation, of course, on it. But I see that if an individual says, "Look, I'm not satisfied with it," if it was my staff, I would expect them to come to me and say, "I'm being challenged on this one," and I would review it and I would either reverse the decision if I felt there was a legitimate

reason, or if I upheld my worker's decision, then I would expect that I would be the first one to have to notify whichever committee that we do have some disagreement here.

I think the important thing is that it doesn't become a shouting match of them versus us; it has to be recognized that this is the individual's right to do this. Nobody is perfect, and I think that we clearly need some kind of an appeal procedure. I expect also that it would be available to the long-term care facility to appeal for some reason and I would like it, because in the times that we have convened the appeal committee in the past, it has always been me who has convened it, because I wanted a person in an institution, usually a chronic hospital, and the chronic hospital was saying, "No, we can't provide the care," and I've been saying, "Look, somebody's got to look after this individual"

So I see the appeal as having a much wider approach, shall we say, or scope, than just the client. I agree with the previous speaker, who said there should be an appeal for the facilities.

Mrs O'Neill: Have you brought that forward in your discussions with the officials you mentioned earlier?

 \boldsymbol{Mrs} $\boldsymbol{Caygill:}$ We talked about that at length today.

Mrs O'Neill: How do you feel that's going?

Mrs Caygill: I feel that, from the perspective of the people who are employed to be doing the design, they feel very comfortable with this. In fact, we didn't seem to have any disagreement on that at all. Obviously it will depend upon you, the people who make the major decisions, as to whether their work and their outlines will be accepted. But I think that if you were to speak with them now, you would see that they would agree with many of the things, from the PCS perspective, that have been discussed by people coming here.

One thing I wouldn't agree with is the delay. I was listening to the gentleman who said placement coordination will slow things down. What we found is that it doesn't slow it down. What it does is enables—for instance, you get someone who comes in and says, "I think my mother should be in a nursing home," and once you start to investigate, you find that's totally inappropriate. So, immediately, you're offering them a plethora of services from which they may choose, and sometimes, if they go directly to the institution, they wait for nine months, their turn comes up and when they get there, the home says, "Oh, my God, we can't look after you," and they've waited all that time in sort of anxiety.

The other fascinating thing that you'll find in the literature is that, if you make information available to people and they know there are options and they know there is some safety net out there, they're not really as demanding of the service, and funnily enough, they use less. The more they know about what's available, the less service they use. We have 4,500 applications a year for admission to a long-term care facility in Hamilton. We've never placed more than 100 to 1,000 in the 23 years we've been in business.

Mrs O'Neill: And you're just facilities; you don't guide people to other community care?

Mrs Caygill: Sure we do. That's the first move because, you see, some people already have the services of the hospital; they have the discharge planner or the social worker in the hospital. Some are on the home care program, so they have their help. Some of them have been applying, we'll say, to a home for the aged, and they have been redirected to a PCS because the home for the aged wants to make sure this is an appropriate location. So the first thing we're doing is to look to see what's available for them out there, because the majority of people are going to stay at home.

This gentleman spoke about social admissions. I was sort of twitchy with that because I thought, "What do you mean by 'social'?" For instance, if you live alone and you're terrified of things that go bump in the night, that's not a social admission; you really need that because your anxiety level is such that you're not functioning normally. I think you have to recognize that because people then begin to have bizarre feelings and they'll start feeling that, "Somebody's in my apartment; they keep coming in; they steal my mail," because their hearing is off. I think there was somebody here whose hearing is poor; mine is. I hear things. I can even hear what sound like voices in the distance, but they're not there and the elderly people are the same.

Mrs O'Neill: Thank you very much.

Mr Jim Wilson: Mrs Caygill, I very much appreciate your attitude with respect to consumer choice and I'm very pleased to hear your determination in that regard. Is the Health Services Appeal Board the appropriate board to be making the appeal? It's been suggested to us that perhaps we should be setting up a long-term care board.

Mrs Caygill: Let me tell you what I said earlier today. You know, once you make things so formal and so cut and dried, it becomes a very adversarial situation. Frequently, you can deal with things by negotiation. If, for instance, a person is not satisfied, he really doesn't want to wait a month, six weeks or two months until some decision is made. Let's be realistic. You can't convene appeals swiftly all over a province. You can't do them within 24 hours.

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I'd like to see a situation where, if there appears to be an impasse, and this definitely is a problem, why couldn't we go to the area managers to begin with? They don't have a vested interest but they might be able to arbitrate appropriately for us and then, if it seems a reasonable thing to do, that might be the route to go, to go further than that.

I feel we haven't really accepted the concept of the area manager and what they can do and what we could use them for fully. If we're going to decentralize, let's put them in that position of being able to look at the community. They know what's going on there. Similarly, if you have a disagreement—I was asked this. Supposing a PCS says to somebody: "Why won't you take Mr X? I can't see any reason why you wouldn't take him. You just don't like him for some reason," and there's an impasse there, then I think the area manager would be the one to arbitrate on

that and say, "Look, PCS, you're being unreasonable in expecting them to take him," or, "Long-term care facility X, you really are being unreasonable in not taking him." I think that way you've kept it in the community and you've had them respond to the community needs rather than having a legal stepwise progression.

Mr Jim Wilson: I appreciate your comments and I just want to tell you that I don't think any members of the committee have suggested anything negative about the placement coordination services that are in place, in fact. I think we all are aware in our own areas of the waiting lists and the inaccuracy of those waiting lists for many of our facilities and the need for coordination. Some of us come from areas where placement coordination services don't exist, so it is going to be new for our areas.

Mrs Caygill: Please don't misunderstand me. This is not misrepresentation on the part of the facilities; they have no other way of knowing. They have no way of knowing whether what they've got is accurate or not, so it's not their fault.

Mr Jim Wilson: Yes, and I think all sectors, the charitable, the municipal and the nursing home sectors that I've talked to, agree that many years ago they should have, on a volunteer basis, gotten better coordinated. Given that they haven't, I think there's a real role to be played for placement coordination.

Mr O'Connor: A lot of the questions I was going to ask, of course, have been answered and you certainly have presented it quite well. Before I became a member of the Legislature I used to build cars in Oshawa and on occasion, when the pension rep was on vacation or whatever, I advised people on what their pension benefits were and advised them as to the dollars and cents. Of course, like a placement coordinator, you take all the information and I certainly wouldn't be a person to go and tell somebody, "Well, it's time you retired." I mean, it's a very personal decision, just like the placement coordination and choice. It's something they've got to decide for themselves.

Through the course of the hearings, we have heard from countless people saying: "We think there needs to be an appeal process. There's got to be choice and choice has got to be paramount." It's one thing that we have heard and I think, as we finish the hearings right now and go into clause-by-clause, you're fitting into the committee hearing process because you've spelled out and maybe addressed some of the concerns we've got. In your form you've shown us, it seems a little bit vague, but I guess there's a lot of the discussion that does take place in the placement perhaps that we don't hear about. Maybe you could just expand a little bit about some of that process.

Mrs Caygill: Are you talking about the last page? Mr O'Connor: Yes.

Mrs Caygill: What's happened, you see—that's a home care case manager. Home care case managers and PCS coordinators live in each other's pockets. For instance, in ours we have an intercom directly with the home care because we're all in the same building under the same administration. Usually what happens is that the case manager will identify there's a real crisis situation coming up and, I've

got to tell you, some of them are incredibly bizarre unless you're actually in the business. So they'll come in—and whatever I quote is something that's really happened over the years. A case manager will come in and say to one of my coordinators: "Look, I've got this case. He's going to put a knife in her back. We've got to move one of them quickly, okay?" That's the start of it. We get the material in very quickly. My coordinator is talking to the case manager. They're working backwards and forwards: how they can do this; how they can quickly get the consent; how they can get the information from the physician; how we can deal with the institution. We might do that all in one day, because we can't allow this to go on because we might have a major catastrophe.

So this little thing is really a confirmation of what's gone on and it's really for the file. These things are filled in so that we know, yes, the family agreed; no, the client didn't; what did we do about it if the client didn't agree.

That's what that is. Most of it is done backwards and forwards. Most of it is done by telephone, because we have to work quickly. There would be a lot of negotiation perhaps with that family member who was at risk, a lot of discussion with him or her, and that's just one example.

Mr O'Connor: So the process we've heard about—we've heard it called bureaucratic—I think really is a very personal process that does allow the consumer as much choice as possible. You don't offer a bureaucratic process. I think you've reassured us of that.

Mrs Caygill: It can't be bureaucratic. I certainly wouldn't work in it and I certainly wouldn't have been here as long as I have, which is 18 years in this particular one. If you could meet the coordinators and the directors, you'd find they all think the same way.

Mr O'Connor: Thank you very much.

Mrs Caygill: By the way, Madam Chair, may I just say one thing? I would like you all, when you are making your decision, to realize that not all old people are in institutions. I don't know the number, but there's a very surprising percentage of people who are over 100 who are living alone. In the placement coordination service grouping, we have one lady who's 110 and she lives alone in her own house. I think you have to recognize that's happening more and more. So when you're talking about elderly persons, please don't look at them all together. I'm getting up there and I don't want to be classed as one of those who needs help yet.

The Acting Chair: Thank you very, very much for your presentation. You did bring something unique to us and I thank you for that.

Mrs Sullivan: I have some questions which I'd like to put to the ministry and to the parliamentary assistant before we leave. First of all, what is the position of the manual vis-à-vis the regulations?

Mr Jim Wilson: That's a very good question.

Mr Wessenger: I will ask ministry staff to indicate.

Mr Quirt: The expectations of the government will be laid out in three places—in the bill before you, in regulations that will be drafted within the powers of the bill, and third, in more specific standards for service delivery and guidelines. In other words, good advice on how to deliver services in a long-term care facility will be included in the program manual.

The program manual will contain those practice-related things that need to be updated on an ongoing basis. There will be provincial expectations laid out in standards, but they'll change as the practice in the long-term care field changes. As we've mentioned earlier to the committee, we have a commitment from both provider associations and consumer groups to meet on a regular basis on a standing committee to review that manual so that if page 68 is confusing or if there's a better way to do things than is recommended on page 68, we'll tear that one out and mail everybody a new page.

There are three different levels of provincial expectation: those in the bill before you; regulations affecting things like the funding formula, resident payments; and third, a program manual that details standards of practice and provides guidelines and advice to facilities on how to do the best job possible.

Mrs Sullivan: Which piece of information then, the manual, the regulation or the legislation, or which in combination, will be used as a judgement with respect to the withdrawal of funding or reduction of funding from a facility if the facility is seen not to be in compliance? All three? One?

Mr Quirt: Possibly all three, possibly one of those three. But I remind you that through the compliance management program, every effort will be made to assist the facility to improve service so that sanctions would be used only as a last resort. The specific withdrawal of funding is most likely to be a contravention of the service agreement or a contravention of the regulations or the act that would seriously affect the safety and welfare of the residents in the facility.

Also, funding would be reduced, of course, if facilities didn't spend the money they were approved to spend in the provision of quality of life programs or nursing and personal care. For example, if they were approved to spend \$2 million on nursing and personal care and only spent \$1.5 million, that's all the money the province would provide.

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Mrs Sullivan: If there is not agreement between the facilities and the ministry with respect to the content of the manual—I'll give you an example. In the nutrition section of the second draft, by example, it appears that whoever has written this assumes that all long-term care patients will be able to eat in a restaurant facility or circumstance, at a table in a communal environment. That is not what happens in most nursing homes. Every person who is there cannot function that way. Then what?

Mr Quirt: In that particular instance it's widely recognized by ministry staff that there are some clients who cannot eat in a congregate setting. It's also expected practice in long-term care facilities, and certainly the expectation of practitioners in every home for the aged and nursing home in Ontario, that every resident should be

given that opportunity to be up and sitting normally to eat in a congregate setting with other people if it's at all possible. Most DONs take pride in the fact that every one of their residents is up and able to interact with other people. They're not at all happy if residents deteriorate to the point where it's no longer possible. They clearly recognize that there are some residents who will require to be fed in their own bed or their own room.

Mrs Sullivan: Or to feed residents who can't swallow.
Mr Quirt: That's correct. But as is the case within the industry, the emphasis is on maintaining the optimal level of functioning of all residents in the facility. That's cer-

tainly the objective.

Mrs Sullivan: I understand what the objective is, but what I'm saying is, if the manual does not reflect reality and homes are, as a result, in non-compliance—

Mr Quirt: I would be very surprised if the manual in its current state—and I haven't read the dietary section recently—made it a requirement that all residents would be fed in a congregate setting.

Mrs Sullivan: It comes very close to that.

Mr Quirt: I think it would certainly establish a standard that all residents would have their meals in the most normal and independent manner possible and that all residents who required assistance in eating would be provided with that assistance and would require that all residents who required a special therapeutic diet would get it and standards to that effect. If in fact the program manual contains something silly and unachievable, I think we'd hear about that very quickly through the committee I mentioned and would make the necessary adjustment to it.

Mrs Sullivan: I use that one as an example, but just in terms of implementation.

The next question is, could you review with us again, as you did yesterday, the question of bridge financing? If this legislation does not pass quickly and is not proclaimed quickly, where are our homes left in terms of financing for 1993?

Mr Quirt: The government has provided two bridge funding initiatives for nursing homes and charitable homes

for the aged. The first one provided funding effective September 1, 1991, and provided an additional amount of funding April 1—I'm sorry; I'm off by one year, I believe—September 1990 to April 1, 1991. The facilities were required—I think I might be off by a year again.

Mrs Sullivan: Yes, you are.

Mr Quirt: I'm going to have to get that chart.

There have been two bridge funding initiatives. The first one required all nursing homes to come to a particular level of staffing in that they were at various levels, anywhere from two hours of nursing and personal care per day per resident to some facilities providing over three. The bridge funding initiative was provided on the expectation that all nursing homes would achieve, in two equal increments, 2.25 hours of nursing and personal care per day. The second bridge funding initiative provided, coincidentally, an equivalent amount of money, another \$1.32 per day, and there was no additional expectation of staffing in that second bridge funding initiative.

Those bridge funding initiatives were designed to allow facilities to respond to the serious financial situations they were in up until January 1, 1993, which was, as you well know, our first target date for the implementation of levels-of-care funding. The legislative schedule, the policy development schedule, did not let us meet that January 1, 1993, date, and no decision has been taken, as I think Mr Wessenger indicated yesterday, on either an economic adjustment or an additional bridge funding initiative for facilities. As has been mentioned previously, we would hope to introduce levels-of-care funding as soon as possible after the Legislature would approve passage of Bill 101.

Mrs O'Neill: Could we have a date for the clause-by-clause, Madam Chair?

The Acting Chair: I was just about to tell you that, Ms O'Neill. This brings to a close the hearings on Bill 101, An act to amend certain Acts concerning Long Term Care. We will reconvene March 23 for clause-by-clause, but the clerk will be in touch with everyone should that date change or to confirm. The committee stands adjourned.

The committee adjourned at 1726.



Substitutions present / Membres remplacants présents:

Carter, Jenny (Peterborough ND) for Mr White
Hope, Randy R. (Chatham-Kent ND) for Mr Drainville
Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer
Malkowski, Gary (York East/-Est ND) for Mr Owens
O'Connor, Larry (Durham-York ND) for Mr Gary Wilson
Sullivan, Barbara (Halton Centre L) for Mr Daigeler
Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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Patti Bregman, volunteer
Leisureworld Inc
Herman Grad, president
David Cutler, vice-president, operations
Villa Care Centre
David Jarlette, administrator
Royal Canadian Legion
Dave Gordon, deputy district commander, District G
Jim Margerum, district commander, District G
Dr Joel Sadavoy
Victorian Order of Nurses, Simcoe county branch
Melody Miles, executive director
Victorian Order of Nurses, Waterloo region branch
Elizabeth Allan, executive director
IOOF Senior Citizens Homes Inc
Cindy Trapp, director of finance
Don Mills Foundation for Senior Citizens, Inc
Joseph Bogdan, board member
Bill Krever, president and chief executive officer
Association of Placement Cordination Services of Ontario
Joyce Caygill, president

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Tuesday 23 March 1993

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Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993



Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée

Chair: Charles Beer Clerk: Douglas Arnott Président : Charles Beer Greffier : Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 23 March 1993

The committee met at 1015 in room 151.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993 LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DUIRÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. Welcome to the first of two days of clause-by-clause discussion of Bill 101, An Act to amend certain Acts concerning Long Term Care.

Before we begin our proceedings, I'd just like to note a couple of things. One, Alison Drummond, our researcher, had distributed the summary of the presentations and all members should have received that. In addition, there were some documents which the clerk had distributed during the break from the last hearings.

What I propose to do is to begin by asking each of the two critics and the parliamentary assistant if they wish to make some opening remarks of approximately 10 minutes each. Following that, we would then move directly into clause-by-clause.

As members will have noted from the government amendments, the Liberal amendments and the Conservative amendments, because of the nature of the act, there are similar if not identical amendments made in three different acts. In the discussion on the first range of amendments, I'm quite prepared to accept that comments might be made related to all of the acts that are going to be affected and to allow some leeway there, simply so that we don't have to keep repeating arguments. In each case, however, we will have to read the full amendment into Hansard so, as we come to it, we'll need to do that as well.

With all that being said, we can begin our proceedings. I would call on Ms Sullivan, if she has any opening remarks.

Mrs Barbara Sullivan (Halton Centre): Thank you, Mr Chairman. As you know, this bill is the first part of legislative consideration of long-term care reform. I think that one of the difficulties we have had in dealing with this bill on all sides of the House is that the government's full policy intentions and implementation plans are not available to us.

We have been dealing with a bill which is fundamental to ensure equity in funding of long-term care facilities in isolation from other matters that are key in the entire long-term care process. The chronic care role study is not available, and our understanding is that it will not be available for some time. The policy announcement and the response to the consultation are not available to us and will not be

available for a few weeks at least, and perhaps longer, I'm given to understand. The implementation plans are not available.

Many people who were associated with consultation with respect to this bill in the first go-round in fact didn't have access to the proposed manual so, as a consequence, much of the original discussion that we faced was a discussion that was being conducted in a vacuum.

As we look at the bill—and we have all come in with piles of amendments, whether it's the government or whether it's our party or the third party. Many of those amendments overlap and are similar. A large reason for that is that we have heard the same responses from many people who have appeared before us and believe that the responses that have been put forward have some validity.

As you know, going through the hearing process, we were very concerned that the government spell out—and while Mr Quirt spelled out for us that the policy intent was that there be choice for the resident and a necessity that the resident consent and participate in developing a plan of care and so on. While that was on the table verbally, it was not included in the act and, as a consequence, there was an enormous sense of unease both from the consumer groups and from the provider groups.

We all, I believe, not having reviewed the third-party amendments at this point, have included a discussion and amendments that would mean that there will be a resident bill of rights, that there would be a resident council, that there would be choice available to the resident that would reflect the resident's own selection of place and a preference for place that would include the resident's ethnic, cultural, religious, social and other backgrounds, including geographic, and that they would be a part of the placement coordinator's decision.

Throughout the hearings, we have been deeply concerned and we will have a number of amendments with respect to the funding of the plan of care. In our view, there needs to be an assurance that the copayments plus the government payments will in fact cover the resident needs and we will have amendments to that effect. We believe that the homes, the long-term care facilities, are being asked to guarantee a plan of care and the delivery of that plan of care with no concomitant guarantee that the plan of care will be funded.

We certainly are aware that there are different levels in the funding and the basic plans of care as they exist now in homes are differently funded depending on the capability of the organization with respect to municipal funding or with respect to charitable funding or whether it's an individual company which is providing services. The equity in the funding that will be coming forward we think is a positive step. However, we believe firmly that there should be an obligation on the state, when it is requiring standards, to ensure that funding is provided for those standards.

As we go through the amendments, we will see areas where we will be accepting without change government amendments. Some we will have some recommendations with respect to, in which case we'll be withdrawing our own amendments or setting our own amendments aside. I'm sure the third party will be doing the same thing.

As you know, my party voted in support of the principle of this bill. We believe strongly that there should be reform of the long-term care process and that it should be moving ahead quickly. We would like to see and have more assurance that the steps that will be taken are cost-effective, that what is spoken is in fact what will be delivered and that where there are promises, those promises will in fact be kept.

We want to see the next steps as quickly as possible in the long-term care process. We think that frankly the government's approach in this bill is backwards and we should have had the policy before we start to have part of the implementation.

I could go on. I know my colleagues are anxious to get to the bill, so I'll leave it there.

Mr Jim Wilson (Simcoe West): Thank you for the comments from the Liberal Party. To echo some of those comments and add some of my own, I think it's disturbing that as opposition members—and in fact members of the government should be disturbed—we're being asked to pass this legislation and today go into clause-by-clause for this legislation really in a policy void.

We don't know because we haven't seen the chronic care role study, for example, or we haven't seen the bigger picture of long-term care, a number of studies and reports the government has yet to supply to the committee members or to members of provincial Parliament. I'm disturbed that we're doing this in a void.

None the less, I want to make it clear from the outset that my party is supportive of the principles of this legislation. We in no way intend to hold up the passage of this legislation because, and I want to be quite frank about it from the outset, we're kind of in a catch-22. We see some major problems with the legislation. We'll attempt to address those, and in a moment I'll outline 10 points we want to see changed in the legislation. But we are forced, on one hand, to go ahead with the legislation because a number of nursing homes in particular require the new funding that will be provided with the new levels-of-care funding.

Having said that, my preference, as a legislator and as someone trying to be responsible to the people of Ontario, would have been that we take more time with this legislation and await the bigger picture, because there's been a lot of attention paid through the media these days to the fact that many of our frail elderly and seniors in Ontario are quite worried about the direction long-term care is taking in this province.

When you approach legislation and the whole longterm care framework in a piecemeal fashion, as this legislation does, I don't think it is good policy development and I don't think it's fair to have senior citizens of the province, their care givers and loved ones worried about where they might be placed some day and how they might be placed in a home in the nursing home sector.

I want to say also that we're committed once again to the passage of this legislation. We think, in principle, that the legislation does set out to really strengthen the role consumers will play if the government goes forward with its amendments and accepts some of our amendments. We think funding will be fair as a result of this legislation but, as was mentioned previously, it's important that there be rights and responsibilities on both sides.

This legislation is written in a way and within an ideological framework that I think shows the government is somewhat suspicious of care providers, and nursing home operators in particular. There are a lot of safeguards introduced by the government to ensure that institutions live up to their end of the service agreements, but there are no safeguards in the legislation to ensure that the government itself pays for and lives up to its end of service agreements. Our amendments will try to address that.

Specifically, the PC amendments we are moving to include in the bill are grounds on which a facility may refuse an admission. All members are aware that the placement coordination system as envisioned in the legislation gives great powers to a single person, namely, the placement coordinator. It doesn't give the right of refusal to institutions where they may not have the proper physical structure. They may not have sufficient nursing skill levels and nursing care available in their home, among other reasons, to refuse the admission of a potential resident.

We want to ensure that the bill is amended to give some rights to institutions along that line because we think it's fair to consumers. We think people shouldn't be inappropriately placed and we think institutions must have a significant say on the mix of care to be provided in their home.

We want to introduce a more generic term for "quality management." I think there's been a great deal of evidence brought before the committee to suggest that the current wording in the legislation which speaks to quality assurance is an outdated term and that quality management and quality management systems are better used in this day and age.

We want to ensure enhanced accountability in the legislation by allowing for more opportunity for appeal in terms of placement coordinators: facilities and government are to be held accountable for their actions. We have a number of amendments, as does the Liberal Party, to ensure that accountability is built into every process envisioned in the legislation and that appeal mechanisms are put in place for both consumers and facility operators.

We want to ensure that placement coordinators are more responsive. Bill 101 currently envisions the placement coordinator position as holding a considerable amount of discretionary power to decide who is eligible for residency, the immediacy of their need to be admitted and to which facility an applicant will be admitted. The placement coordinator should be answerable for these decisions and we'll be introducing amendments to ensure that happens.

We also want to introduce an amendment to ensure that people who are placed on waiting lists aren't simply ignored, that waiting lists are reviewed by the placement coordinator every six months and that the needs of individuals on waiting lists are assessed periodically.

1030

We want the removal of preference for not-for-profit facilities. This is going to be a contentious amendment that probably the other two parties don't have in their repertoire of amendments. If one looks at the example the government has set in terms of rent control, where it has clearly told the province and landlords that part of your rent includes capital and future capital improvements, we believe that it's only fair that all sectors of the nursing home business—nursing homes, charitable homes for the aged and municipal homes—be treated the same with respect to capital funding and that there not be a bias in favour of the charitable and municipal homes as opposed the privately operated nursing homes, and we'll go into that argument in greater detail when the amendment is put forward.

We want to protect consumer choice and particularly we want to protect the choice and respect the dignity of Canada's veterans. I think that we've heard most compelling evidence from veterans' organizations, from the Royal Canadian Legion, from Legion Command, that they're very fearful this legislation will shut them out of their own homes, on which they've worked very hard and put a great deal of money towards developing.

We also want to ensure that spouses aren't left out and that there's a preference set up to ensure that spouses are readily admitted to homes where their partners may be in residence. To do that, we're setting up a priority rating system which I think varies both from what the Liberals have envisioned and certainly what the government has put forward in Bill 101.

We want to ensure there's a role for physicians in the assessment process of applicants, and we'll be introducing some amendments on behalf of the Ontario Medical Association in that respect. We want to ensure there's an inclusion of the residents' bill of rights that's already contained in the Nursing Homes Act and, to give credit where credit is due, I think the opposition parties have been able to force the government to introduce an amendment and I see that in its repertoire of amendments it is looking forward to including the bill of rights, which I think is only fair and proper.

Finally, we want to ensure there's a creation of a dispute resolution mechanism. The inclusion of a third-party arbitration mechanism is a standard contract clause. In the circumstance that there is a dispute concerning the service agreement, that is, disputes regarding the interpretation of, compliance with or ability to comply with the service agreement, this amendment will ensure that a resolution is fairly reached by a neutral party. We think it's in the interest of fairness that this amendment be accepted by the government.

I look forward to the debates which will be long but hopefully fruitful. At the end of the day we all want to see the best possible legislation in place, Mr Chairman, and you have my commitment and that of my colleague Mr Jackson to ensure that is the case.

The Chair: Thank you very much, Mr Wilson. I now call on the parliamentary assistant.

Mr Paul Wessenger (Simcoe Centre): I'd like to thank the opposition members for their comments with respect to this legislation and I too look forward to dealing with the clause-by-clause and coming up with the best possible legislation.

Certainly, this legislation very much needs to be dealt with expeditiously. I think we're all aware of the levels of inequality with respect to the funding of the various nursing homes and homes for the aged and certainly it's very important that we have this level-of-care funding brought into effect in order that we have fairness to residents, in order that we have financial viability and also that we have funding to reflect residents' needs and services delivered.

I would object to one comment made by one of the opposition members. Certainly it's the intention of this government not to have a system which provides for openended funding. I think we all have to live within the realities of financial circumstances, and open-ended funding is not a policy option for any government today.

With respect to the whole question of reform, I would agree this is a partial reform but I think we must take our windows of opportunity and do what reforms we can when we have the opportunity to do that reform. I think it's important that we move forward and we not lose an opportunity to move forward. I would suggest that certainly this is very much a part of the reform of long-term care and will fit well with the policy statement that will shortly come out.

With respect to this legislation, certainly the hearings indicated the need to give and to ensure that we have the priority of consumer choice with respect to the facility or with respect to community care. Certainly, it's been very much the priority of this government to ensure that consumer choice is paramount, and I think that must take precedence over other issues. We have to ensure that consumer choice is paramount, subject of course to the aspect that a person should not be placed in areas where the physical facilities cannot serve that resident or the nursing care doesn't have the necessary expertise to provide the personal care.

With respect to the matter concerning veterans, I'm not going to deal with all the individual items because we'll have much discussion on them. I would like, though, to table at this time a copy of a letter from the Minister of Health addressed to the Honourable Kim Campbell, Minister of Veterans Affairs, with respect to the matter of priority beds concerning Perley. I think Mr Wilson indicated he wanted something with the minister's signature, and certainly this is the signature, which clearly indicates that the minister believes the priority beds at the Perley Hospital are protected, and it certainly was intentional that they be protected, asking the Minister of Veterans Affairs, Kim Campbell, to confirm that that is the federal government's understanding as well. I'll file that now.

The only other thing I would like to suggest to the Chairman is that, seeing the fact that we just had a large number of amendments presented by both opposition parties, it might be more productive to have a short adjournment so that those amendments might be looked at.

Mr Cameron Jackson (Burlington South): Collated properly.

Mr Wessenger: Yes. So I'd request maybe a half-hour adjournment.

The Chair: There has been a request for a half-hour adjournment. It's a little after 25 to 11.

Mrs Yvonne O'Neill (Ottawa-Rideau): Why don't we make it to 11. Mr Chairman?

The Chair: Would 11 o'clock be reasonable? Okay? The committee will stand adjourned until 11 o'clock.

The committee recessed at 1037 and resumed at 1103.

The Chair: The standing committee on social development will begin again its clause-by-clause deliberations on Bill 101. I think everyone has all of the amendments. We'll begin the first amendment to the bill, a Liberal motion. Ms Sullivan

Mrs Sullivan: I move that the definition of "appeal board" in section 1 of the Charitable Institutions Act, as set out in section 1 of the bill, be struck out and the following substituted:

"'Appeal board' means the Long Term Care Facilities Review Board under the Nursing Homes Act."

The Chair: Are there any comments? I'll just allow some discussion of that amendment.

Mrs Sullivan: Yes, if I might, Mr Chairman. This amendment is a precursor to subsequent amendments that I will discuss now, because while they appear at different points in the bill, they all relate to the same issue.

We have been very concerned about the nature of the appeal board which is being selected to deal with issues that will be coming to it with respect to long-term care and long-term care facilities. Our purpose with this amendment and with subsequent amendments would be to reconstitute the nursing homes review board as the long-term care facilities review board under the Nursing Homes Act, and that board would then become the basic long-term care appeal mechanism.

As well, we would provide a new set of responsibilities to that board, which would be to act as an arbitrator and to settle disputes with respect to the service agreements between a home for the aged or a municipal or charitable home and the government. So what we're seeing here is a combination of issues coming together. The Nursing Homes Review Board, which has had activity and expertise in the past, would then be reconstituted to take on a broader scope of long-term care issues, and as well would also have a new authority that would allow it to act as an arbitrator in addition to being an appeal board.

We certainly feel there must be a dispute settlement mechanism that would be available to the homes, and we feel there should be additional expertise associated with the operation of the appeal board itself. The Health Services Appeal Board is now significantly behind and there is a significant delay in the timing of cases that are appearing before it. If that board is going to have to be reconstituted to do the work required by this act, then why don't we reconstitute a board that already has responsibility in the area?

Mr Jim Wilson: While I appreciate the thrust and principle behind this Liberal amendment, we will not be supporting it in the Progressive Conservative caucus. I will admit, though, that we had thoughts along the same lines, either to extend the mandate of the Long Term Care Facilities Review Board under the Nursing Homes Act, or originally, my caucus had drafted up amendments setting up a separate appeal board other than the Health Services Appeal Board. We dropped those, feeling that it was perhaps too bureaucratic.

To ensure that facilities have a right to appeal, that consumers have some appeal powers and to ensure that there's third-party arbitration in terms of arbitrating any disputes that may surround service agreements, we decided it's probably best to extend the powers of the Health Services Appeal Board that's now in place, not to add any new layers or to create any other boards.

I think Mrs Sullivan is correct in terms of the need for arbitration and the need for proper appeal mechanisms. Hence, we support what she's trying to do but can't support the particular amendment.

Mr Wessenger: We will not be supporting this amendment. I would like to indicate that we certainly recognize the need to develop a mechanism; however, I think it's very important that it be done in consultation with all the groups that are involved. I think the minister has indicated this is an item that should be dealt with in phase 2 of the legislation. I think we all recognize we have to deal with the problem, but this is not the appropriate time to do it because we need to do the consultation process and we have to work out the best way possible. At the same time, we don't want to add a level of bureaucracy without making sure it's going to work well.

The Chair: I'll put the question then. Shall the amendment carry? All those in favour? Opposed? The amendment does not carry.

The second amendment, Mrs Sullivan.

Mrs Sullivan: I move that section 1 of the bill be amended by adding the following definition to the Charitable Institutions Act:

"'Resident' means, in the case of an approved charitable home for the aged, a person admitted to and lodged in that home."

We are putting this amendment and will have a similar amendment to the other act.

This definition is included now in the Nursing Homes Act. We feel it presages the introduction of the fundamental principle, the residents' bill of rights and the council. As I've indicated, 'resident' is defined in the Nursing Homes Act and we believe should be defined in the other acts as well. It's really a technical amendment. It's not a big-deal amendment, but it is a technical amendment that I think should be there.

Mr Jim Wilson: I'm inclined to recommend that we support this amendment because I think it does clarify a definition that may need clarification, but I would be interested in legal counsel's opinion on this particular amendment.

Mr Wessenger: I think, because this is a technical amendment, we should have legal counsel's opinion on it.

Ms Gail Czukar: Gail Czukar, legal counsel with the Ministry of Health. For consistency's sake, it would be the same definition as in the Nursing Homes Act. I don't see any problem with it legally. I think the reasons that have been given by the member are the ones that are appropriate for why it's there.

Mr Wessenger: Based on that, certainly I'll be voting in favour of the amendment then.

The Chair: Shall the amendment carry? Carried.

Shall section 1 of the bill, as amended, carry? Carried.

We then move to what will be a new section of the bill. I call on the parliamentary assistant to present the government amendment.

Mr Wessenger: I move that the bill be amended by adding the following section after section 1:

"1.1 The act is amended by adding the following ection:

"Fundamental principle

"3.1(1): In interpreting a provision of this act or the regulations that applies to an approved charitable home for the aged and in interpreting a provision of a service agreement between the crown in right of Ontario and an approved corporation maintaining and operating an approved charitable home for the aged, the fundamental principle to be applied is that an approved charitable home for the aged is primarily the home of its residents and, as such, it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others.

"Residents' bill of rights

"(2) An approved corporation maintaining and operating an approved charitable home for the aged shall ensure that the following rights of residents of the home are fully respected and promoted:

"1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse.

"2. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

"3. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

"4. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

"5. Every resident has the right to keep in his or her room and display personal possessions, pictures and furnishings in keeping with safety requirements and rights of other residents of the home.

"6. Every resident has the right,

"i. to be informed of his or her medical condition, treatment and proposed course of treatment,

"ii. to give or refuse consent to treatment, including medication, in accordance with the law and to be informed of the consequences of giving or refusing consent,

"iii. to have the opportunity to participate fully in making any decision and obtaining an independent medical opinion concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from an approved charitable home for the aged, and

"iv. to have his or her medical records kept confidential in accordance with the law.

- "7. Every resident has the right to receive reactivation and assistance towards independence consistent with his or her requirements.
- "8. Every resident who is being considered for restraints has the right to be fully informed about the procedures and the consequences of receiving or refusing them.
- "9. Every resident has the right to communicate in confidence, to receive visitors of his or her choice and to consult in private with any person without interference.
- "10. Every resident whose death is likely to be imminent has the right to have members of the resident's family present 24 hours per day.
- "11. Every resident has the right to designate a person to receive information concerning any transfer or emergency hospitalization of the resident and, if a person is so designated, to have that person so informed forthwith.
- "12. Every resident has the right to exercise the rights of a citizen and to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the residents' council, staff of the approved charitable home for the aged, government officials or any other person inside or outside the approved charitable home for the aged, without fear of restraint, interference, coercion, discrimination or reprisal.
- "13. Every resident has the right to form friendships, to enjoy friendships and to participate in the residents' council.
- "14. Every resident has the right to meet privately with his or her spouse in a room that assures privacy and, if both spouses are residents in the same approved charitable home for the aged, they have a right to share a room according to their wishes, if an appropriate room is available.
- "15. Every resident has a right to pursue social, cultural, religious and other interests, to develop his or her potential and to be given reasonable provisions by the approved charitable home for the aged to accommodate these pursuits.
- "16. Every resident has the right to be informed in writing of any law, rule or policy affecting the operation of the approved charitable home for the aged and of the procedures for initiating complaints.
- "17. Every resident has the right to manage his or her own financial affairs if the resident is able to do so and, if the resident's financial affairs are managed by the approved charitable home for the aged, to receive a quarterly accounting of any transactions undertaken on his or her behalf and to be assured that the resident's property is managed solely on the resident's behalf.

"18. Every resident has the right to live in a safe and clean environment.

"19. Every resident has the right to be given access to protected areas outside the approved charitable home for the aged in order to enjoy outdoor activity, unless the physical setting makes this impossible.

"Further guide to interpretation

"(3) Without restricting the generality of subsection (1), a provision of this act or the regulations that applies to an approved charitable home for the aged and a provision of a service agreement relating to an approved charitable home for the aged shall be interpreted so as to advance the objective that the resident's rights set out in subsection (2) be respected.

"Deemed contract

"(4) An approved corporation maintaining and operating an approved charitable home for the aged shall be deemed to have entered into a contract with each resident of the home, agreeing to respect and promote the rights of the resident set out in subsection (2)."

What this amendment does is add a residents' bill of rights to the Charitable Institutions Act and make it a term of a deemed contract between the home and its residents. Currently, this same bill of rights is in the Nursing Homes Act. This amendment addresses the concerns raised in the hearings that the residents of homes for the aged should have the same bill of rights protections as nursing home residents

The Chair: We'll begin with Ms O'Neill.

Mrs O'Neill: I'm very happy that this amendment has come forward on behalf of the government. I am very happy about the right to consent regarding medical treatment, because I think that's something that was brought to us by many people. I don't know how to identify these sections or whatever they are. I have one question, however, regarding the one that's designated number 17.

The reason I bring it forward is because of course, as some of you know, I've just been through some of this, and I find it confusing. I don't see anybody acting on behalf of the person except the home. Many of the residents of such facilities often have a power of attorney designated to either a relative, trust company or other responsible person or body. I don't know whether this is the time to try and do that or not, but certainly we're not facing reality in this as I read it cold off this piece of paper. Maybe there's an explanation for it; maybe it's somewhere else.

Mr Wessenger: I assume that the concern you're raising is the fact that there may be a resident who is not capable and has a power of attorney appointed.

Mrs O'Neill: Right. Who is given the quarterly accounting? If the resident is incapable, there's no indication of who is given that quarterly accounting.

Mr Wessenger: I'll ask legal counsel to see if they can answer. I would normally think that the power of attorney would be entitled to that, but I'll ask them to clarify.

Ms Czukar: If there is a power of attorney or a committee under the Mental Incompetency Act that has the legal authority to manage the financial affairs of a resident, then the rules for accounting would be in the power of attorney

or in the court order appointing the committee, and they would be separate from this. This only addresses the issue as between the home and the resident, so that if the home is managing the resident's affairs through a trusteeship or some kind of arrangement between the home and the resident, then it's an obligation on the home to give a quarterly accounting. But if there is someone else managing the resident's affairs, then it would have to be governed by the law or the agreement that's made in that case.

Mrs O'Neill: I'm glad we've got that on Hansard anyway, because it definitely is a question.

Mrs Sullivan: We will be supporting this amendment, which is very similar to our own. I think it's an improvement on our amendment, because it does include the service agreement, and I think that's an important aspect. I wonder if we could have an additional explanation from counsel or the parliamentary assistant with respect to the deemed contract, which I don't believe is in the Nursing Homes Act bill of rights.

1120

Mr Wessenger: Yes, you're quite correct; it is not in the act. One of the problems is with respect to the enforceability of bills of rights. I think it's fair to say that even with this provision, it doesn't—it gives some additional protection by allowing the individual to have a right to sue the home if they're in breach; it gives them a contract right. I think that's the basic reason for putting in, to give a right, a means of enforcement, to the individual resident. It will be added, by the way, to the Nursing Homes Act as well.

The Chair: Mrs Sullivan?

Mrs Sullivan: Thank you. That's fine.

Mr Jim Wilson: We will be supporting the government's amendment, which establishes a fundamental principle clause and entrenches the resident's rights in legislation. As members will know, the Ontario PC party had drafted a very similar amendment to address this area of Bill 101. Bill 101, as it was originally drafted, did not adequately address the ethnocultural, spiritual, linguistic and social requirements of applicants to and residents of long-term care facilities. Concern has repeatedly been expressed that Bill 101 could erode the multicultural nature of many facilities and lead to the overlooking of the special needs of ethnic seniors. Presentation after presentation drove home the point that Bill 101 cannot be allowed to overlook these concerns.

To illustrate this point, I want to quote from the briefing material provided by Villa Colombo, which houses a significant number of Italian seniors in the Metropolitan Toronto area. Villa Colombo is just one of many groups we've heard from on this matter. They write:

"There are currently 70,000 seniors in Metro Toronto whose mother tongue is Italian, a number larger than the total population of many cities in Ontario such as Barrie, Kingston or Peterborough. Many of these seniors are unable to adequately communicate in English. No senior can truly live with dignity if that senior cannot communicate needs in a language which they understand. Our moral obligation lies in representing the best interest of the seniors."

With this amendment, I believe the appropriate emphasis is placed on cultural, spiritual and linguistic needs when individuals apply for admission to a long-term care facility. By inserting the fundamental principle clause of the Nursing Homes Act into the Charitable Institutions Act and the Homes for the Aged and Rest Homes Act, placement coordinators will be required to be mindful of these special ethnic needs as well, and I just echo what the parliamentary assistant has already assured us. To ensure that, though, we will be proposing that the residents' bill of rights from the Nursing Homes Act also be applied to the other acts, and the inclusion of the bill of rights will ensure that the dignity of individuals living in these settings is recognized and respected.

Finally, I just want to take up a point that has been raised by Mrs Sullivan. I just want to make sure that it's absolutely clear to the public and all of us non-lawyers that in no way can a service agreement or other contractual agreements between the home and the state override the bill of rights or the fundamental principle clause. I would just like that clarification.

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The Chair: Parliamentary assistant?

Mr Wessenger: I'll ask legal counsel to reply to that one.

Ms Czukar: I'm sorry; I didn't hear the question. It was a long question.

Mr Jim Wilson: We're just looking for the assurance, in layman's language, that the bill of rights and the fundamental principle clause can't be overridden through the contractual arrangements such as the service agreement.

Ms Czukar: The service agreement is a contractual arrangement between the government and the home. Do you mean, could the government or the home override it by some matter of agreement?

Mr Jim Wilson: I note that the government has come a long way by what it has done here in terms of inserting the bill of rights and the fundamental principle clause. There was a lot of discussion in committee about social aspects of admissions, and the word is included in the wording now presented by the government, which I'm very, very pleased to see. But I do have a worry, because of some of the discussion we had in committee between the parliamentary assistant and opposition members, that through service agreements or other regulations that may set out placement coordination, these fundamental rights and principles could be somehow abrogated or avoided.

Ms Czukar: The bill of rights doesn't have precedence over other provisions of the act per se, but the initial subsections do say that the service agreement is to be interpreted in light of, and that provision was to be put in there to ensure that if there is any conflict between a provision of the service agreement or the act or regulations, as it stated, the bill of rights would have to be considered. There's nothing that says specifically it has precedence, so it's not clear which would necessarily take precedence. I think the commitment is to respect the bill of rights in any of those instruments, regulations, acts or the service agreement.

With respect to the issue of social admissions, however, I would point out that the bill of rights applies to

residents and, given the amendment that was just passed that applies the definition of "resident" from the Nursing Homes Act to this act and will be in the homes for the aged act as well, we're talking about someone who is admitted to and lodged in the home. So it doesn't apply to the placement process before someone becomes a resident of the home.

Mr Jim Wilson: Had I known that, I probably wouldn't have supported the inclusion of the definition of "resident," and I ask the committee's indulgence to perhaps reconsider that. Is that possible?

Mrs Sullivan: No.

Mrs O'Neill: Not at this point.

Mr Jim Wilson: Maybe I should ask the mover of the "resident" definition clause whether they took into consideration that this would not affect admissions, which I think is rather serious.

Mr Wessenger: I think there are other sections of the act that would be more appropriate than this section, if you want to try to deal with that issue. I think the basic coordinating clause would be the area that should be addressed.

Mr Jim Wilson: I understand, and I also understand what the government is saying and legal counsel is saying with respect to the fact that the bill of rights and the fundamental principle clause are there to ensure that it must be respected in interpretation of other parts of the act. I appreciate that, but I just want to be clear with the public, who I think put a great deal of trust in our Charter of Rights, that this is not a charter of rights, this is a bill of rights, and there is a fundamental difference in practicality and in law.

Mr Jackson: I think my point was covered, but from the careful words chosen by legal counsel, it's clear that there's an override clause in here that gives enormous powers that wouldn't necessarily be guided by the bill of rights at all. I just want to put that on record.

The Chair: Mrs Sullivan, did you have a final—

Mrs Sullivan: I think our colleague from the third party was blurring the issue somewhat.

Mr Jim Wilson: I was clarifying the issue.

Mrs Sullivan: Having been the mover of the motion which included the definition of "resident" in the other act, where it does not now appear, I know that subsequent amendments would ensure that the placement coordinator would take into account, during the admission process and the eligibility determination process, the social and cultural issues associated with that process. There is also attached to a later amendment an indication that the plan of care should take into account those factors as well.

The Chair: Mr Wilson, final comments.

Mr Jim Wilson: I appreciate the clarification set forth by Mrs Sullivan of the opposition party. It may surprise you, Mrs Sullivan, but we do know what we're doing over here. I simply wanted to ensure that legal counsel clarified on the record that the bill of rights is a residents' bill of rights, because I think a lot of the presenters and witnesses we had before the committee—and I don't think this is particularly funny—were of the impression that if we were

to insert a bill of rights and a fundamental principles clause, it would affect admissions and applicants. I just want to make it clear that that's not what we're doing here.

I had a lot of groups in my office, as I'm sure you did, Mrs Sullivan, indicating that if we only inserted that bill of rights and fundamental principles clause, all our problems would be solved with respect to placement coordinators.

Mrs Sullivan: That's not right.

 $Mr\ Jim\ Wilson:\ You're correct. That isn't correct, and that's not what the effect of what we've just done will be.$

1130

The Chair: We should perhaps call upon the ghosts of Mr Diefenbaker and Mr Trudeau to come forward and talk about the bills and charters, but the points are—

Mr Jackson: Why don't you call the question, Mr Chairman?

The Chair: I intend to. Shall the new section 1.1 carry? Carried.

We would then move on to section 2.

Mr Jim Wilson: Both the PC and Liberal amendments to 1.1(1) are deemed to be dropped, then?

The Chair: Yes. Having not been presented, they are deemed dropped. So we will then move to section 2 of the bill, and the first amendment is a Liberal amendment. Ms Sullivan.

Mrs Sullivan: I move that clause 5(1)(e) of the Charitable Institutions Act, as set out in subsection 2(2) of the bill, be struck out and the following substituted:

"(e) operate an approved charitable home for the aged unless.

"(i) the approved corporation is a party to a service agreement with the crown in right of Ontario that relates to the home; and

"(ii) the service agreement complies with this act and the regulations."

Mr Chairman, this is a drafting amendment, if you like, to the section, which now would require that the home complies with the act and the regulations, when in fact the intent of the section was that the service agreement comply with the act and the regulations. This particular amendment was requested for clarification from the Ontario Nursing Home Association. The wording they recommended is slightly different from this, but counsel has indicated that this is the more appropriate and clear way to go, and that's why I'm putting it forward.

The Chair: A comment, Mr Wilson?

Mr Jim Wilson: Mr Chairman, I think it is an appropriate amendment, and we'll be supporting it. I think it's important to ensure the inclusion of the words "the service agreement complies."

The Chair: Thank you. Parliamentary Assistant?

Mr Wessenger: We'll be accepting this amendment, because it's clearly the intent of the original section and this perhaps clarifies it somewhat better than the original.

The Chair: Just before asking for the vote on that, I should have asked first, does subsection 2(1) carry as in the bill? Carried.

Shall the motion of Ms Sullivan carry? Carried. Shall subsection 2(2), as amended, carry? Carried.

The next amendment is a Conservative amendment. Mr Wilson

Mr Jim Wilson: Mr Chairman, I move that the bill be amended by adding the following section after section 2:

"2.1 Section 6 of the act is amended by adding the following subsection:

"Exception

"(2) The minister may not direct payment under subsection (1) to an approved corporation erecting a new building or an addition to an existing building, if all or any part of the new building or the addition is to be used as an approved charitable home for the aged."

The Chair: Do you wish to comment on that?

Mr Jim Wilson: Yes. As part of Bill 101, the NDP has suggested that the Nursing Homes Act be amended to allow the government to provide capital funding for not-for-profit service expansion. This move comes on the heels of the government's earlier indication that it intends to drastically alter the opportunity commercial providers will have to provide home care services in the province. These policy directions obviously have more to do with, I believe, the NDP ideology than pragmatism or the redirection of the system of long-term care in order to meet the present and future needs of Ontarians.

The government has trumpeted Bill 101 as a means by which to make the long-term care sector equitable. Both the provision of capital funding for only not-for-profit nursing home facilities and the restrictions to be placed on commercial home care services, which we've heard the minister talk about, fly in the face of this intent with regard to equity.

In 1989 the Ontario Nursing Home Association successfully won a court battle launched to address the inequitable and discriminatory treatment of residents in nursing homes, compared to residents of homes for the aged. The court found that the system of funding was illogical and unfair and urged the province to move swiftly to rectify the problem back in 1990. Funding for nursing home residents remains as much as 30% to 40% lower than that provided for residents of other facilities.

So, in effect, Bill 101 will attempt to undo one funding problem, because it attempts to make funding among the nursing home sectors more equitable, but it will create another funding problem, and to me and my caucus this makes no sense. It follows, therefore, that capital funding arrangements should be eliminated from the legislation governing the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act.

Additional capital funds should not be provided at all by government, given the new per diem arrangements, since they are in fact included in the per diem. In light of this, I propose that not-for-profit facilities be required to use their dollars the same as for-profit facilities, and therefore I move that direct payments under subsection 2(1) of the act not be allowed.

I add to that the NDP's own logic when it's applied to rent controls. The NDP has told us time and time again

that a portion of any individual's rent to a landlord includes payment for any future renovations or modifications or capital improvements or additions that a landlord may want to introduce to the facility in future, and therefore the government caps any rent increases at I think around 5% this year or a little over, and allows in part of that and slightly above that a provision for capital. The argument we're making here is to apply that logic to Bill 101.

The bill has this clause, which clearly states a bias for the not-for-profit sector when it comes to capital grants from the government. We believe that the not-for-profit sector should be treated the same as commercial operators or the for-profit sector when it comes to capital improvements or expansion, capital funding, ie, a private nursing home operator must save his or her pennies and reinvest its profits into capital improvements or expansions down the line. We believe that charitable homes that are now going to receive—everyone's receiving the same per diem in this levels-of-care funding arrangement-should also be required to save their pennies, as the nursing home operators must, and reinvest savings into capital expansion, without having the benefit of additional capital grants from the government. Otherwise, you're introducing further inequities into a system, and we're told that this government's intent and the intent of this legislation was to eliminate those inequities.

Mr Wessenger: We will be voting against this provision. It's somewhat interesting that what the opposition has moved here is to change a policy, in fact legislation, that existed for many years and that provided for 50% funding for homes for the aged for capital. It's something that, I must say, existed under previous Conservative governments in the past and continued under the Liberal government of the past.

Mr Jim Wilson: That doesn't make it right.

Mr Wessenger: No, it's just interesting to note that the change in the—

Mr Jim Wilson: Nice point of history there.

Mr Wessenger: I know. It's interesting just to point to a change in policy for that opposition party. But we certainly support the non-profit sector and would not support any taking away of rights for homes for the aged. Therefore, we'll be consequently voting against it.

1140

The Chair: Shall Mr Wilson's motion carry? All those in favour? Opposed? The motion does not carry.

I believe the next amendment is also a Conservative amendment. Mr Wilson.

Mr Jim Wilson: I move that the bill be amended by adding the following section after section 2.1. Actually, Mr Chairman, I'll withdraw this amendment, because it was a housekeeping item referring to the previous motion.

The Chair: It is therefore withdrawn.

Shall section 3, as in the bill, carry? Carried.

Now section 4. The first amendment with respect to section 4 is the Conservative amendment. Mr Wilson.

Mr Jim Wilson: I move that section 4 of the bill be amended by adding the following sections to the Charitable Institutions Act, after section 9:

"Notice before reduction or withholding

"9.0.1(1) Before reducing or withholding a payment to an approved corporation under subsection 9(3), the minister shall serve on the approved corporation a notice setting out.

"(a) the minister's proposal to reduce or withhold a payment under subsection 9(3):

"(b) the proposed amount of the reduction or the amount proposed to be withheld, as the case may be;

"(c) the breach or breaches of the service agreement on which the minister relies for reducing or withholding payment;

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board:

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the approved corporation at its most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) An approved corporation that is served with a notice under subsection (1) is entitled to a hearing by the appeal board if it mails or delivers to the minister and to the appeal board, within 30 days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If the approved corporation does not require a hearing in accordance with subsection (4), the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) The approved corporation may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal board,

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for the extension; and

"(b) may give such directions as it considers proper in light of the extension.

"Hearing

"(7) If the approved corporation requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

"(9) The parties to a proceeding before the appeal board under this section are the approved corporation, the minister and such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 9.8(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section.

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal;

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to make a reduction or withholding under subsection 9(3) in such lower amount;

"(b) may, if the minister has carried out the proposal under subsection (5),

"(i) find that the proposal was reasonable in the circumstances:

"(ii) direct the minister to pay to the approved corporation the amount of the reduction or the amount withheld, as the case may be; or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the approved corporation the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable:

"(c) may substitute its opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on Appeal

"9.0.2 On appeal to the Divisional Court from a decision of the appeal board under section 9.0.1, the Divisional Court,

"(a) may affirm or rescind the decision of the appeal

"(b) may substitute its opinion for that of the minister or the appeal board; and

"(c) may exercise all the powers of the appeal board."

The Chair: Just before commenting on your amendment, could I just note to committee members that this is actually a new section. I'm going to allow the discussion of this but we will not vote on it until we have dealt with the first Liberal amendment and the government amendment. But because it has been read in and is fresh in our minds, we'll have the discussion of that now.

Mr Jim Wilson: Under the heading "Appeal opportunity if found in breach of service agreement," I just want to make the following comments. Throughout the public hearings on this legislation, this committee has repeatedly been told that the system must provide adequate opportunity to appeal decisions at various points of the process. It

is through appeals that the system remains accountable and responsive.

The Ontario Nursing Home Association has rightly noted in its presentation to this committee that Bill 101 will create a highly—

Mrs O'Neill: Litigious.

Mr Jim Wilson: —very legalistic—environment through its move towards contractual arrangements between government, provider and resident.

Just for Ms O'Neill's sake, I use notes so that I can stick to the point.

Mrs O'Neill: I'm sorry I disturbed you.

Mr Jim Wilson: If this is indeed the way in which the long-term care system is to be redirected, the system must be balanced with the opportunity for facilities to challenge decisions which will greatly affect their ability to operate and care for their residents.

With this amendment, an opportunity will be created for facilities to appeal decisions of the minister to reduce or withhold funding. I think this is very important. This committee is well aware that there is no accountability on the government side to provide the funds proportionate with requirements set out in the service agreements. What must be recognized by this committee is that withholding funds hurts residents. It doesn't necessarily hurt the operators; it hurts the residents themselves directly. For this reason, this measure should be used wisely and with caution. The amendment I have moved recognizes this fact.

Finally, the amendment also addresses the fact that sanctions for facilities in breach of their service agreement have been increased and can be imposed in an arbitrary fashion without an appeal process being available for the facility. In many cases, sanctions such as freezing admissions or withholding payments will in fact jeopardize the provision of care to existing residents in the facilities themselves. For these reasons, sanctions should only be implemented as a final resort and facilities must have the right to appeal the sanctions implemented.

Mr Wessenger: We will not be voting in favour of this resolution for some of the comments previously made. First of all, the question of the appeal process is being considered in phase 2, and also, seeing that this provision deals with the service agreement, it is subject to judicial review and subject to lawsuit in the courts. This is a contractual aspect.

Mr Jim Wilson: Perhaps repeat it, because I'm not sure I caught it all. There's going to be a phase 2? This is certainly news to me and I think to all members of this committee, because this is the first time phase 2 has been discussed. Secondly, there is an appeal board in this legislation. So I fail to see how the parliamentary assistant's comments jibe with some of the government's own provisions.

Mr Wessenger: I think, first of all, with respect to the matter of agreements, normally disagreements with respect to contractual agreements are dealt with in the courts, although parties may elect sometimes to deal with them through arbitration. That's the first point I would make.

The second point is, I think it was made very clear by the minister at the beginning of these hearings that this was phase 1 of the long-term care reform and there would be a phase 2 of the legislation with respect to the community aspect of long-term care.

Mr Jim Wilson: Maybe I should correct myself, Mr Chairman. I thought the parliamentary assistant's original comments were referring to phase 2 of clause-by-clause or something in this particular legislation.

Mr Wessenger: No, of course not.

Mr Jim Wilson: I'd be happy to have a couple more days.

Perhaps I may, before the Liberals have an opportunity to comment, very clearly state that it's our belief the minister shouldn't be allowed to withhold payments to a facility without properly notifying and allowing for an appeal mechanism for the facilities, because members must be aware that while facility operators come and go, residents live in those facilities; it is their home.

If money is withheld to that home, for breach of service agreements or whatever reason, the residents themselves are the ones who will suffer. It seems reasonable and fair to me and my caucus colleagues that there should be a notice provision in the legislation, a requirement that the minister serve notice and, secondly, that there be an appeal of what could be a very heavy-handed decision put forth by the minister to withhold funding to homes and residents.

Mr Jackson: Briefly, the point is that the manifestation of this is that generally with staff layoffs, the problems are in meeting payroll, not in acquiring food, so this has serious implications for potential immediate staff layoffs and it becomes a self-fulfilling prophecy and a snowball. How do we undo that? One of the major motivating reasons the government has gotten into this process of equity is not necessarily because of the equity between residents in the different homes, but because there were extensive layoffs in nursing homes because payrolls couldn't be met and nursing homes were going into receivership. I think we get a false sense of the equity base of a nursing home, but the manifestation of cutting off funding generally results in staff layoffs.

The legislation is inadequate in terms of meeting the needs of health care workers in these facilities all across Ontario. Our amendment would at least allow a period of time in which labour can also come to the table and discuss these matters where the government is stepping in and trying to deal solely with an owner of a facility. This allows labour to also participate and discuss the implications of cutting off funding to their institution. Again, everybody would be focused on residents' needs, but the manifestation is layoffs, because there's no money to make the payroll. We strongly believe that these concerns should be addressed in this legislation. That's why my colleague and our caucus has presented them.

Mrs Sullivan: I believe this is a serious and important amendment which the third party has put forward. We have, for our part, put forward two or three other amendments which speak to some of the issues but not all of the issues, and which expand on some of the issues raised in this amendment with respect to the withdrawal of funding. We are quite concerned about (a) the drafting of the act and (b) what the actual practice will be when the law is implemented.

We feel, first of all, that because there is no mechanism now included in the bill, there ought to be a legislated process with respect to serving notice on the home that the inspector believes is in breach, which states specifically why the home is in breach. That is not included in the bill.

The second area where we feel this is an important motion is that if funding is reduced, we know the funding is based, according to this act and according to levels of service, which is what we're moving to, on plans of care. When funding is reduced, the plans of care then will not be able to be implemented at the same level they would be if the plans of care were fully funded.

Therefore, what we are concerned about is, how much at risk to their health or safety will residents be put if funds are withdrawn because of what may in fact be merely a technical breach of a service agreement, rather than a breach of the agreement which is a significant one and in which there is danger to the residents?

I'm going to ask if we could have the concurrence of the parliamentary assistant to stand this motion down for them to reconsider the nature of the motion and bring it back. I think this is not a frivolous motion. It is not put forward merely for words to be placed on the table and for the issue to come forward.

The point that the parliamentary assistant has raised with respect to the appeal board, in my view, is not an appropriate response, in that the appeal board will in fact be operating to hear appeals with respect to eligibility, and I believe that the government will also, as I recall from its amendments, be further enhancing the role of the appeal board.

The appeal board here I think is the appropriate place to hear appeals with respect to funding reductions. I think the government should look at this amendment very seriously.

The Chair: Mr Wilson and then the parliamentary assistant.

Mr Jim Wilson: I would concur with Mrs Sullivan's comments and I certainly appreciate the support of the Liberal Party. The only addendum I would place is that I don't want to see, if the parliamentary assistant concurs with standing down the amendment, that it be stood down indefinitely. I went through that during the advocacy and consent legislation. We had several dozen clauses stood down indefinitely. So I would ask that the matter be dealt with before 5 pm today.

The Chair: Parliamentary assistant.

Mr Wessenger: First of all, in response, certainly we don't feel the present appeal board would be the appropriate board to hear such issues that are raised in this, because they are contractual issues and legal issues and require a board able to deal with those types of issues if the decision was made to have it. Also, I understand that there was filed, I believe with members, an answer to a request for

information with respect to a process prior to withholding funding. I believe that has been filed with members, so there is a process that will be used prior to that withholding funding aspect being dealt with.

The Chair: Shall the motion presented by Mr Wilson carry? All those in favour? Opposed? The motion does not carry.

Mr Larry O'Connor (Durham-York): Is it in order to do it out of order?

The Chair: We can vote again later, if you wish.

Mr O'Connor: We don't need to vote again. I just wondered.

The Chair: Thank you very much. Shall section 4, subsection 9(1) as in the bill, carry? All in favour?

Mr Wessenger: There's an amendment, I believe, isn't there? Legal counsel seems to know. Yes, there is an amendment, a Liberal motion.

The Chair: Yes. That is a new section.

If you'll bear with me, we have to deal with 9(1) as in the bill. Shall it carry?

Mr Wessenger: Carried.

The Chair: Carried. Then we have a Liberal amendment. Mrs Sullivan.

Mrs Sullivan: I move that section 9 of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by adding the following subsection:

"Payments must be sufficient.

"(1.1) The payments under subsection (1) must be in such amounts that the payments, together with any amounts for which residents are responsible, are sufficient to defray all the costs described in subsection (1)."

Basically, what we're saying is that the obligation of the home in providing accommodation, maintenance, operating costs, care, services, programs and other goods to residents is clear and set out from the service agreements. We know funding can be withdrawn from the homes for any breach, whether technical or not, of the service agreements. We know the resident will be responsible for certain copayment with respect to the accommodation portion of the costs. We do not, however, see an obligation on the government, which is requiring that a plan of care be met, to fund the plan of care.

This amendment is one which says that the payments, which will be made out of the appropriations from the

Legislature to assist in defraying the maintenance and operating costs, will be sufficient, along with the resident's accommodation copayment, to cover the costs required to provide the care and services needed by the resident.

The Chair: Comment, Mr Wilson?

Mr Jim Wilson: I'm pleased to note that we're very supportive of this amendment. Given that, I think it begs the whole question of the direction in which this bill is taking the province in long-term care in terms of funding. We're moving away from an insurance model, which ensured in the past that if doctors assigned an extended care certificate, the per diem provided by the government had to go to the home whether the government wanted to provide it or not, and that was a legislated requirement.

I know this deals with operating subsidies for homes for the aged, but to me the Liberal amendment attempts to say in simple language that if the government's requiring that certain services in care and accommodation be provided, then the government better be prepared to put its money where its mouth is, and it better be prepared to actually provide enough money to all of the nursing homes and the entire sector to ensure that people are getting the services and care that's outlined in the service agreements.

I'm happy to see the amendment, because I'll tell you, we struggled with legislative counsel for many a day and night trying to come up with a similar amendment, and while this may not be perfect in law, certainly the intent is commendable and I think all members should support it. If we have to stand it down and reword it, because I know legal counsel may have some objections to where it's placed and how it's worded, I hope the parliamentary assistant, on behalf of the government, will at least support the amendment and perhaps we could work on wording, if necessary.

Mr Wessenger: We will not be voting in favour of this motion because in effect it's open-ended funding and as a policy matter we're not prepared to have open-ended funding.

The Chair: Shall Ms Sullivan's motion carry? All those in favour? All those opposed? The motion is defeated.

It now being shortly after 12 of the clock, we will adjourn until 2 o'clock sharp.

The committee recessed at 1204.

AFTERNOON SITTING

The committee resumed at 1409.

The Chair: Good afternoon, ladies and gentlemen. We begin the next session of the standing committee on social development, and we are dealing with Bill 101, An Act to amend certain Acts concerning Long Term Care. The next amendment we are dealing with is a government amendment, and I'll call on the parliamentary assistant.

Mr Wessenger: I move that subsection 9(3) of Charitable Institutions Act, as set out in section 4 of the bill, be amended by striking out "is in breach of" in the third line and substituting "has breached."

This is a technical amendment to cover the situation; otherwise, there has to be a determination of when the breach occurred when the payment's being made. So in order to avoid that technical problem, we've changed the words.

Mrs Sullivan: I don't want to belabour this point, because we did speak about the difficulty we have with the approach of the government with respect to the withdrawal of funding when there is a breach. First of all, the home is not entitled to notice of the breach. We now have an amendment, which is a technical amendment, that would enable funding to be withdrawn for a breach that has occurred at some point in the past yet to be determined.

The third thing is that yes, we have had an informal statement on what the process will be, but that's not part of the law in terms of what occurs if a home is in breach of a service agreement. Whether the breach is a tiny technical one or the breach is a major one out of which charges should flow, it doesn't matter: The same rules apply, and none of those rules are written down.

I think there is an enormous problem with this section of the act and with the entire concept of the withdrawal of funds

as it's been put to us by the government. It needs an enormous amount of more work, and I'm very dissatisfied.

Mr Jim Wilson: I'm sorry, Mr Chairman, but I did not hear at all, even though I was listening, what the technical explanation from the parliamentary assistant was.

Mr Wessenger: The explanation is that the words "is in breach of" mean you'd have to prove, the immediate instant the decision was made to withhold funding, that there was a breach at that instant, and that would make it very difficult to determine. So you put in the provision "has breached," because that's clearly identifiable as having occurred. In the prosecution of any offence, you have to have a definition.

Mr Jim Wilson: Before we leave this important section, I just want to be clear what the policy of this government is. As I understand it, because you won't accept the amendments put forward by the PC caucus or the Liberal Party with respect to an appeal process when it comes to a minister's decision to withhold funding because of a possible breach in a service agreement, then it's the policy of your government that facilities will have no access to appeal and the punishment will apply without any sense of fairness.

Mr Wessenger: Perhaps I might indicate what has been indicated in the answer to the committee with respect to the procedure. First of all, the sanction is only a potential last step in a process, not that is geared to resolve a problem without resorting to stricter sanctions. The process, first of all, is that discrepancies in the service delivery might be observed by government staff and go through the normal compliance procedures. Government officials will obviously deal with the matter by bringing it to the attention of the home orally. Then of course it would be given a written notice of non-compliance.

The notice of non-compliance would not necessarily mean that the sanction would be applied in any way; it would just give notice that the facility must take corrective action. The notice would state specifically what aspects of service provided by the facility are faulty or lacking and request that the facility make a written plan of action to rectify the problems observed. If the problem is corrected, that's the end of the matter. If the facility does not achieve the agreed-upon expectations despite all reasonable supportive efforts by the staff, then the government has the option of withholding or reducing payment, and the amount of money recovered or withheld would be equal to the value of services agreed upon in the service agreement but denied to the residents by the facility.

After the sanction has been imposed, ministry staff will continue to monitor the care and services given at the facility. It's expected that the increased involvement of ministry staff will result in the problem being quickly rectified by the facility. So it's only as a last resort after the compliance approach doesn't work.

Mr Jim Wilson: Mr Chairman, through you to Mr Wessenger, I appreciate your reading to us from the memo that's been provided to members of the committee with regard to the process. I have to tell you again, though, that I don't take the same level of comfort, and I don't think residents of nursing homes or long-term care facilities, as they're to be called in the future, should take comfort.

If you're so crystal clear and so confident that withholding of funding is definitely the last resort, then why don't we put that in the legislation? Why don't we put what you just read into legislative language? I'm not trying to be rude or anything. I'm just trying to figure out why, if it's so clear, we can't have it in the bill, or at least an appeal mechanism?

Mr Wessenger: If we look at the whole question of compliance with law in general across society, I think it's fair to say that if we had a process where every breach of the law was prosecuted, every breach was dealt with legally, we'd have the whole system come to a standstill; that's across our whole system, criminal law included, police included.

Mr Jim Wilson: We have very few laws, Mr Wessenger, in which the state holds all the cards, and when we do have circumstances where the state holds most of the cards, we allow citizens to appeal, we allow citizens access to mechanisms that seek to remedy an injustice that the

state may impose on an institution, for example, or an individual. What we're asking for in this case is the ability for an institution to appeal a unilateral decision by the minister

Mr Wessenger: If we're getting to that aspect, I think we've indicated that that is a matter for consideration in phase 2 of the legislation, as the proper way of dealing with appeal processes. But I might add that I think any government would have to be very careful about any action it would take with respect to withholding funds, on the basis that it would have to be very certain in contracts it would write and that it had a very good legal case before it would take such action, because it would be exposing itself to substantial damages, as in any contract between any two parties. It would be the same type of situation. In fact, in a commercial situation the normal process, when one private concern feels that the other private concern owes it money, its normal process is to not pay and to withhold payment.

Mr Jim Wilson: But we also know that in reality, Mr Wessenger, if there isn't an easy appeal process that's inexpensive, the case is that when nursing home operators, for example, are running on thin margins, when so many of them are in fact on the verge of going bankrupt, the last thing they're going to do is take on the state in court to seek to correct an injustice because of unilateral breach of contract. It's an expensive process. I don't know why we can't just make it easier and fairer.

Mr Wessenger: I think I could concur in the sense that yes, we need in phase 2 to see if there's a better appeal mechanism than through the court system. I certainly would concur that we probably can, once we've done the proper type of consultation and looked at the proper type of board, come up with a better approach than through the courts. I would concur, and I certainly would support coming up with some proper overall appeal procedure in phase 2.

The Chair: A final question, Ms Sullivan.

Mrs Sullivan: I just wanted to point out that, where there's any other breach of any other law, there is at least a notice given to the person who is breaking the law, whether it's a parking ticket or a charge that's laid. In this case, the notice isn't even given. The question now, with the wording change with respect to breach, is that the offence, if you like, could have occurred at any point in time. I just think this is a very bad law.

The Chair: Shall the motion moved by Mr Wessenger carry?

Those in favour? Opposed? Carried.

The next amendment is a Liberal amendment. Ms Sullivan.

1420

Mrs Sullivan: I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.1:

"Federal funding for veterans

"9.1.1 If an agreement between the government of Ontario and the government of Canada relating to veterans provides for funding from the government of Canada relating to long-term care, any such funding received by the

province must be used for the purposes for which it was provided."

The Chair: Do you want to just explain the purpose of that?

Mrs Sullivan: This is a companion amendment to a later one which would be put. As you know, the veterans appeared before the committee on more than one occasion to indicate that there was deep concern among the veterans that the priority for admission and eligibility under federal-provincial agreements for beds which were held and funded by the government of Canada would not be maintained. This is an indication that since an agreement has been entered into and funding paid, that's how the money should be used.

The Chair: Ms Sullivan, in reading this motion, I have to take you to the orders of the House, section 56 of the standing orders, which says:

"Any bill, resolution, motion or address, the passage of which would impose a tax or specifically direct the allocation of public funds, shall not be passed by the House unless recommended by a message from the Lieutenant Governor, and shall be proposed only by a minister of the crown."

I'm going to have to rule this motion out of order, and do so rule.

Mr Randy R. Hope (Chatham-Kent): Are we now going to depend on you to make all rulings?

The Chair: That's normally one of the functions of this job.

Mr Hope: But I was going to bring it to the committee's attention, so from now on we can rest assured that you're going to screen all these amendments that are coming forward?

The Chair: I'm sure that if I am not on top of my job, you will remind me.

Mr Hope: Okav.

The Chair: The next amendment is a Conservative amendment.

Mr Jim Wilson: I move that clause 9.2(1)(a) of the Charitable Institutions Act, as set out in section 4 of the bill, be struck out and the following substituted:

"(a) shall provide that it continues in full force and effect until replaced or cancelled in accordance with the regulations:

"(a.1) shall contain a dispute resolution mechanism for resolving disputes related to the service agreement;

"(a.2) shall provide for a right to arbitration if the dispute resolution mechanism fails to resolve a dispute;

"(a.3) shall contain the other provisions required by the regulations to be contained in a service agreement."

The Chair: Commentary?

Mr Jim Wilson: This amendment outlines in part what the PC caucus would like to see contained in a service agreement. As Bill 101 currently reads, the service agreement could technically expire, leaving an operator unable to operate his nursing home facility or long-term care facility, as it's now called. My amendment would ensure this cannot happen.

As well, this amendment makes first reference to a dispute resolution mechanism for service agreements, and I will later introduce an amendment that would see to the establishment of such an mechanism. We think it's another extremely important amendment. It's a commonsense amendment that has been asked for, particularly by the Ontario Nursing Home Association.

I would hope all members would support it because, again, we're talking to what appears in the legislation to be a unilateral and heavy-handed approach to service agreements. I would state that my reading of Bill 101 is that all the cards are stacked in favour of the state, ie, the government of the day, and that operators have very little say in how they may be dealt with by the government.

Mr Wessenger: We'll be voting against this resolution on the basis that the whole matter in respect to appeal should be dealt with in phase 2.

Mrs Sullivan: Mr Chairman, as you know, in dealing with the appeal motion which we put earlier on, we had certainly been leaning to a dispute resolution mechanism that, in our proposal, would have involved the appeal board being able to participate in arbitration.

We feel it's important that there be some remedy that isn't a court remedy or a full appeal remedy. We will support this amendment, given that our amendment was defeated, as a second-best alternative, but I suspect that the government is going to do away with this one as well.

The Chair: Mr Jackson, I missed your hand.

Mr.Jackson: Just briefly, Mr Chairman-

Mr Jim Wilson: I'd just note they're brimming with charity over here.

Mr Jackson: My concern is that in the process of the granting of licences in order for a nursing home to operate, which is a fairly strong analogy to this clause which is the right to exist under the service agreement, the Nursing Homes Act sets out clear time frames and expectations in legislation. Again, we've got a situation where far too much is going into regulation.

Although our motion seeks to improve on that, we really wish to set for the record that we're dealing with different levels of protection in terms of what would amount to the rapid transfer of patients in the event of a difficulty, and any mechanism which allows the contract to continue until the matters in dispute are resolved tends to have the effect of keeping a stable environment for the residents.

I don't wish to quote all the medical evidence of the even the loss of life associated with the stress from uncertain mobility and late-night mobility and all that sort of thing that flows from regulations that can allow for service agreements to be cancelled and therefore put licences in jeopardy.

You can choose to see this as an option to help the operator; we choose to see it as an option which helps the residents stabilize their environment. The minimal protections in law under the Nursing Homes Act, we believe, should be extended in this legislation to ensure that residents have full notice that they may have to move because there's a dispute between the operator and the government.

Somehow we have to have the patients part of this equation and they're not.

The Chair: Shall the motion moved by Mr Wilson carry? All in favour? Opposed? Defeated.

The next amendment is also a Conservative amendment. Mr Wilson.

Mr Jim Wilson: This is a housekeeping item that refers to the motion that was just defeated. Given that the government doesn't want to deal with allowing for dispute settlement mechanisms or allowing for appeal processes, there's no house to keep in order so I'll be withdrawing the amendment.

The Chair: The next amendment is also a Conservative motion. You still have the floor, Mr Wilson.

Mr Jim Wilson: I move that section 4 of the bill be amended by adding the following to the Charitable Institutions Act after section 9.2:

"Arbitration

"9.2.1(1) This section applies with respect to arbitrations under a service agreement.

"Notice

"(2) An arbitration is commenced by a party to a service agreement giving written notice to the other party of its desire to arbitrate a dispute related to the service agreement.

"Appointment of board of arbitration

"(3) Within fourteen days of the written notice having been given, the parties,

"(a) shall jointly appoint a member of the appeal board to sit as a board of arbitration; or

"(b) shall each appoint a person to sit on the board of arbitration.

"Same

"(4) If the parties each appoint a person to sit on the board of arbitration, the two persons so selected shall within ten days after the second of the persons has been appointed appoint a member of the appeal board.

"Powers of board of arbitration

"(5) The board of arbitration shall hold a hearing to examine and decide the matters that are in dispute between the parties.

"Service agreements

"(6) Any decision of the board of arbitration shall form part of the service agreement.

"Costs

"(7) The board of arbitration may award costs.

"Appeal to Divisional Court

"(8) A party may appeal a decision of the board of arbitration to the Divisional Court on a question of law or fact or both.

"Powers of court on appeal

"(9) On an appeal to the Divisional Court from a decision of the board of arbitration under this section, the Divisional Court may do one or more of the following:

"1. Affirm or rescind the decision of the board of arbitration.

"2. Substitute its opinion for that of the board of arbitration.

"3. Exercise any power of the board of arbitration."

1430

The Chair: Comments, Mr Wilson?

Mr Jim Wilson: Again, the inclusion of a third-party arbitration mechanism is a standard contract clause in the circumstances that there is a dispute concerning the service agreement, that is, disputes regarding the interpretation of, compliance with or ability to comply with the service agreement. This amendment will ensure that a resolution is fairly reached by a neutral party. A dispute mechanism will ensure that a facility can respond to the requirements set out in the service agreement.

There is no requirement in Bill 101 that the level of funding provided by the government need be commensurate with the level required to provide adequate services and programs to meet the needs of the resident population. There is also no accountability on the government's side to provide the funds proportionate with the requirements set out in the service agreements, and this amendment has been proposed to address these concerns. It will enhance the accountability of the system by making certain that service agreements are reasonable for both sides of the agreement.

The Chair: Thank you. The parliamentary assistant.

Mr Wessenger: We'll be voting against this motion on the same basis as previously indicated. The determination of the appropriate method of appeal should be in phase 2.

The Chair: Ms Sullivan.

Mrs Sullivan: Once again, we find it shocking that the appeal process wasn't one that was thought out as this bill was presented. There's nothing more to say. We'll be voting for this amendment.

The Chair: Shall the motion presented by Mr Wilson carry? All in favour? Opposed? It is defeated.

The next amendment is a Liberal amendment. Ms Sullivan.

Mrs Sullivan: I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.2:

"Term of service agreement

 $^{\circ}9.2.1(1)$ Each service agreement shall be for a one-year term.

"If no new service agreement

"(2) If a new service agreement is not entered into before the expiry of the current service agreement the following provisions apply:

"1. Despite subsection (1), the current service agreement continues in force until a new service agreement is entered into or until the current service agreement is terminated.

"2. Any new service agreement that is entered into shall be deemed to have been in force since the current service agreement would have, but for paragraph 1, ceased to be in force.

"3. Interest shall be paid on all unpaid amounts that, under the new service agreement, should have been paid during the time the new service agreement is deemed to have been in force."

The Chair: Comments, Ms Sullivan?

Mrs Sullivan: This motion is really to reflect the kinds of approaches that in fact will be taken in the service agreements and in the schedules to the service agreements with each of the homes where there is a time line that is specified, where there is a contractual arrangement where services are provided in exchange for funding.

The situation is that nursing homes over the past few years have in fact suffered while negotiations are being entered into and funding does not flow, nor does interest on funding which has to be accessed elsewhere, ie, through bank and other loans. As a consequence, many of our nursing homes, as a result of what has become the standard practice, it seems to me, in the ministry, have been placed in cash flow difficulties which impact on the kinds of services that they are able to provide. In fact we have seen and heard a notice from nursing homes that they are going to have to reduce the services because they are unable to provide the service which is being required of them by the ministry. They simply can't afford it. This amendment is to set that straight.

Mr Jim Wilson: Mr Chairman, I'm pleased to indicate that we'll be supporting this amendment. All other attempts having failed, I'll throw back to Mrs Sullivan some lines perhaps she used at one time. Given that this is probably the second-best attempt, we'll be supporting this.

Again, it's getting a little frustrating on this side. I think that a number of our amendments are quite well thought out, and the government's persistence in not supporting many of them is a bit disturbing.

Mr Wessenger: We'll be voting against this amendment. First of all with respect to subsection 9.2.1(1) and subsection 9.2.1(2), paragraphs 1 and 2, these items would all be covered under the service agreement in any event, and I must say paragraph 3 would be creating a new financial obligation and setting a precedent for the government, so we will not be supporting it for that reason.

Mr Jim Wilson: Can we make a comment on that? **The Chair:** Yes.

Mr Jim Wilson: I just wonder if that is totally correct, that provisions in Mrs Sullivan's amendment are actually part of service agreements now. It begs the question of what happens if a service agreement expires without its replacement being ready. I guess what you're telling us, and perhaps it is correct, is that the service agreement, although it's to be renewed once a year, continues in effect until the new one is put in place.

Mr Wessenger: What I might add is that the normal provision put in a contract at this time says, "This agreement continues in effect until renewed." It's called an evergreen clause, and it's a normal clause that is put in most agreements of this nature.

Mrs Sullivan: I point out that indeed the evergreen clause may well be added to the contract, but that does not mean that money will continue to flow, nor will any increment which is negotiated for the subsequent contract necessarily be retroactive and payments covered. Another thing: How do we know that it's going to be in the service agreement? It doesn't say that in the act.

The Chair: Shall the motion moved by Ms Sullivan carry?

All in favour? Opposed? Defeated.

The next amendment is also a Liberal amendment.

Mrs Sullivan: I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 9.2.1:

"Arbitration where failure to negotiate service agreements

"9.2.2(1) An approved corporation may require an arbitration by the appeal board, by giving notice in accordance with subsection (2), if there has been a failure to successfully negotiate,

"(a) an initial service agreement;

"(b) a subsequent service agreement; or

"(c) amendments to a service agreement in response to changing circumstances.

"Notice requiring arbitration

"(2) To require an arbitration, a notice requiring an arbitration must be mailed or delivered to the minister and to the appeal board.

"Arbitration

"(3) If the appeal board receives a notice under subsection (2), the appeal board shall arbitrate the matters in dispute.

"Parties

"(4) The parties to an arbitration are the person requiring the arbitration and the minister.

"Applicable provisions

"(5) Subsections 9.8(3) and (5) apply, with necessary modifications, with respect to an arbitration.

"Powers of appeal board

"(6) In arbitrating the matters in dispute the appeal board may order the minister,

"(a) to sign on behalf of the crown in right of Ontario, a service agreement with such terms as the appeal board specifies; or

"(b) to sign on behalf of the crown in right of Ontario, an agreement that amends an existing service agreement in such manner as the appeal board specifies."

Once again, you can continue to see the difficulty that we have, where the home is left without any mechanism to challenge what could very well be an arbitrary determination of the ministry. I'll just use (c) as an example, where the determination of the patient classification has been done at the beginning of the year, funding is based on that, the service needs of residents have changed substantially over the course of the year and the home seeks to amend the service agreement. If the ministry says no, then the home has no alternative. The arbitration is there for precisely that circumstance.

1440

Mr Jim Wilson: I'd like to indicate that we're supporting this amendment, and I'd like to ask a question through you to the parliamentary assistant. If the government were not to support some sort of arbitration in the case of a failure to negotiate a service agreement between the crown and a home, what would the process be?

Mr Wessenger: The process of a failure to negotiate an agreement would make, I assume, the home in breach of the act would allow—not necessarily in breach. The existing agreement would continue in effect unless it was terminated by the crown.

Mr Jim Wilson: But this speaks to initial agreements and subsequent agreements. So let's take the case of an initial agreement, failure to come to agreement on an agreement.

Mr Wessenger: I think I'll ask legal counsel, because there might be a differing position with respect to the nature of the facility.

Ms Czukar: If it weren't possible for the crown to negotiate an agreement with the home initially, then funding an operation could not occur, because funding and operating are dependent on a service agreement being entered into. So obviously it would depend on a successful negotiation regarding the service agreement in order for the funds to flow and the operation of the home to begin, and that is the intention.

Mr Jim Wilson: I think you can see the importance, then, of arbitration. Correct me if I'm wrong, but as I was growing up I thought the NDP were great promoters of arbitration such as this.

Mr Hope: Negotiations, not arbitration.

Interjection: Binding—

Mr Jim Wilson: Binding arbitration. Rand formula—

The Chair: Mrs Sullivan, before I ask the parliamentary assistant to respond, do you wish to—

Mrs Sullivan: Yes, I do. I think that the initial service agreement area is one that is also key in that we have 500 homes of various types which will be entering into new service agreements. If there is a failure to enter into a service agreement—those homes are now filled with people and I ask you, what will happen to those people?

Mr Wessenger: I would assume that we're going to have a successful negotiation of agreements, because this level-of-care funding is going to generally provide the increased funding. I don't really anticipate there'd be a problem with the entering into initial provisions.

Mrs Sullivan: It will not. On a point of order, Mr Chairman: It will not guarantee an increase in funding. There are some homes whose funding will be frozen.

Mr Wessenger: I think that's fair to say with those red-circled homes but certainly, as indicated by ministry staff, for most homes there will probably be some financial benefit. Also, funding is going to be based on the common level of care. That's an objective determination. So for that aspect, as far as the funding goes, it's an objective determination as to what the home is going to get. It's not a question of negotiation in the matter of the funding; it's based on an objective determination by the classification system. I don't know whether you wish any further clarification from ministry staff.

The Chair: Mr Wilson, you had one more.

Mr Jim Wilson: The worst-case scenario would be that you can't come to an agreement with a home. I haven't

heard anything that would lead me to believe that that isn't possible under this legislation. Again, I fail to see why you wouldn't want some sort of arbitration to ensure that agreement does come about.

A carrot-and-stick approach is fascinating, Mr Wessenger, given that I think most people are starting to figure out that the carrot's kind of wilting and kind of rotting out there and that the millions of dollars that the sector potentially would gain under this legislation are really in question, I think. And with the red-circling of some homes and other homes expecting that they may be able to get out of deficit positions with the new funding, I think there's a rude awakening coming both to the ministry and to a number of charitable institutions, municipalities and private nursing home operators that the new funding that's been tied to this legislation isn't going to be the cure-all.

The Chair: A final question. Ms O'Neill.

Mrs O'Neill: I'm having a lot of difficulty feeling very secure about this. We had an awful lot of representations about the service agreement and about how uncomfortable many people feel about it. We've just had legal counsel tell us there will be no funds flowed till there is a service agreement; we've had the parliamentary assistant tell us that likely everybody will sign one. If the funding is tied to the time lines and there's no real appeal mechanism, motivator, arbitration process, what kind of atmosphere is this going to happen in? Not everybody in Ontario feels about Bill 101 the way the parliamentary assistant does. I feel very strongly that if everything is going to be put off into phase 2 or when the service agreement is signed and it is going to be signed, I don't think the Ontario providers or the people being provided for-and those are the people Bill 101 should be working towards providing service for feel they are going to have security flowing from this bill.

The Chair: Thank you. Shall the motion moved by Ms Sullivan carry? All in favour? Opposed? It is defeated. We now move on to a government amendment.

Mr Wessenger: I move that clause 9.3(1)(a) of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by striking out "for basic accommodation" in the first line and substituting "for a class of basic accommodation."

The purpose of this amendment is really to allow for different rates to be set out for short-term and long-term basic accommodation.

The Chair: Thank you. Any comments on this amendment?

Shall the government motion carry? All in favour? Opposed? Carried.

Mr Wessenger, you have another amendment?

Mr Wessenger: Yes. I move that clause 9.3(1)(e) of the Charitable Institutions Act, as set out in section 4 of the bill, be struck out and the following substituted:

"(e) for care, services, programs or goods that are not mentioned in clause (a), (b), (c), (d) or (2)(a) and in respect of which the resident has entered into a written agreement with the approved corporation, the amount determined in accordance with the written agreement."

We should stand this one down. I think.

The Chair: You wish to stand it down?

Mr Wessenger: Yes, because until the substitute decision-making amendment is accepted, it's felt it should be stood down

The Chair: So we will stand this down until later. It's your intention to bring it back?

Mr Wessenger: Yes, it is, after we deal with section 9.1 of the bill

The Chair: Okay, so this we will stand down and bring back later. The next amendment is also yours, Mr Wessenger.

Mr Wessenger: I move that clause 9.3(2)(b) of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by striking out "or on behalf of" in the fifth line. The same should also be stood down until the substitute decision-making amendment is accepted.

The Chair: So this will also be stood down. We will return to this.

Another amendment, Mr Wessenger, from the government, if you would proceed with that one.

Mr Wessenger: This one we can go with, it looks like. Oh, I would ask that perhaps this be—

The Chair: This is to be stood down as well?

Mr Wessenger: Yes, because there is an amendment—

The Chair: Would you move it and then we'll stand it down.

Mr Wessenger: Okay. I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 9.3:

"Debt of a resident

"9.3.1 An amount that an approved corporation charges a resident of an approved charitable home for the aged in accordance with section 9.3 for accommodation, care, services, programs or goods is a debt owed by the resident to the approved corporation."

The reason for asking to stand it down is there is a Liberal motion, I believe, that covers the same area that might be—

The Chair: All right, so we will stand down those three until later. We move on now to a Liberal amendment. Ms Sullivan.

Mr Wessenger: Can I ask for a short adjournment, because we might come up with a consideration of a small amendment to Ms Sullivan's motion.

The Chair: I'm prepared to do that. I wonder if we might just have Ms Sullivan move her amendment and then we could have a short break, if members are in agreement. Ms Sullivan, do you want to move your amendment?

1450

Mrs O'Neill: I'm sorry. Before we do that, the parliamentary assistant said we're standing down three. I've only got two. What was the third one we stood down?

The Chair: It is 9.3(1)(e), 9.3(2)(b) and 9.3(1). They were three government amendments and they are stood down.

Ms Sullivan, do you want to just move your amendment?

Mrs Sullivan: Yes. I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 9.3.1:

"Resident responsible for payments for accommodation

"9.3.2 (1) A resident is responsible for the payment of those amounts demanded by an approved corporation for accommodation in accordance with section 9.3.

"Minister to give statements

"(2) The minister shall provide, on the request of a resident, a statement setting out how much the resident may be charged for accommodation under subsection 9.3(1)."

The Chair: We may be able to sort something out all together. So I'm just going to go to the parliamentary assistant.

Mr Wessenger: I'm wondering, Mrs Sullivan, if you might be prepared to accept a friendly amendment to put before the words "on the request of a resident," "annually or" on the request of a resident.

Mrs Sullivan: "Annually or"?

Mr Wessenger: That's right. Because that's the practice.

Mrs Sullivan: Would you accept a friendly amendment that says, "annually and"?

Mr Wessenger: Yes.

Mrs Sullivan: I'd prefer that.

The Chair: To make sure everybody has got that, that would then read, "The minister shall provide annually and on the request of a resident...." Is that correct, Mrs Sullivan?

Mrs Sullivan: Yes.

The Chair: I think we will need you, then, to move that.

Mrs Sullivan: I withdraw my previous motion and move the following.

I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 9.3.1:

"Resident responsible for payments for accommodation

"9.3.2(1) A resident is responsible for the payment of those amounts demanded by an approved corporation for accommodation in accordance with section 9.3.

"Minister to give statements

"(2) The minister shall provide annually and on the request of a resident a statement setting out how much the resident may be charged for accommodation under subsection 9.3(1)."

The Chair: Shall Ms Sullivan's motion carry? All in favour? Opposed? Carried.

The next amendment is a Conservative motion.

Mr Jim Wilson: I move that section 9.4 of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by adding the following subsection after subsection (1):

"No recovery of charge

"(1.1) No deduction shall be made under subsection (1) unless written notice about the fact that the item paid for has not been provided or made available to the resident is given to the minister within ninety days after the date on

which the person from whom the approved corporation accepted the payment discovers the fact."

I was wondering if it would be in order to read the following two amendments and then give my comments. They all deal with the same theme.

Mr Wessenger: I have no objection.

The Chair: I believe that would be in order if there are no objections. Please go ahead.

Mr Jim Wilson: I move that section 9.4 of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by adding the following subsection after subsection (2):

"No recovery of charge

"(2.1) No deduction shall be made under subsection (2) unless written notice about the fact that the payment exceeds the amount permitted to be charged under section 9.3 is given to the minister within ninety days after the date on which the person from whom the approved corporation accepted payment discovers the fact."

I move that section 9.4 of the Charitable Institutions Act, as set out in section 4 of the bill, be amended by adding the following subsection after subsection (3):

"No recovery of charge

"(3.1) No deduction shall be made under subsection (3) unless written notice about the fact that the item paid for has been inadequately provided is given to the minister within ninety days after the date on which the person from whom the approved corporation accepted payment discovers the fact."

The Chair: Please go ahead with your comments.

Mr Jim Wilson: There are three opportunities in which the minister may make payments to reimburse a consumer. These circumstances include when a good or service or services were to have been provided and were not, when a charge for a good or service is deemed excessive or when an item was provided inadequately.

This amendment does not deter from the ability of the minister to compensate the appropriate party in any of the above circumstances. It does, however, put some onus on the person who either failed to receive a service, received an inadequate service or was overcharged for a service to take action on the matter 90 days after the discovery of a problem.

It is important to note that this amendment will in no way limit the chances for recovery, be it a recent event or one year ago. Rather, by using the date of discovery as the starting point for action, this amendment seeks only to have these matters acted upon in a reasonable amount of time. This amendment will ensure that such matters are resolved in a fair way and within a reasonable time frame for both service providers and recipients.

It had come to our attention from witnesses, particularly from, I think, the private nursing homes sector, that at times, if there isn't a time frame put on the recovery section in terms of—I believe the argument was that from time to time somebody may come well after 90 days and say that a service was inadequately provided, a year ago or whatever. They knew the fact a year ago, didn't report it and now continue to refuse to pay for the service. It apparently

happens from time to time concerning deceased residents, former residents, where the family may from time to time refuse to pay for a service.

I think the homes really want to ensure that when someone, either the resident or his or her substitute decisionmaker, discovers that a service hasn't been provided, or is provided inadequately or in the circumstances I've outlined in my amendment, this isn't left indefinite, that it's brought within 90 days to the home's attention and a remedy is sought.

The Chair: Just before asking for comment, we will be voting on each of these individually but we can discuss them all together.

Mr Wessenger: We'll be opposing the amendments because we feel the 90 days is too restrictive a period and that the matter really should be left to administrative practice rather than set out in the legislation.

Mrs Sullivan: We'll be supporting this amendment. I think 90 days is an adequate period of time. If the parliamentary assistant wants to argue why 90 days isn't an appropriate period of time, we might be interested in hearing that, but in my view 90 days is quite adequate.

The Chair: Shall the first motion, amending section 9.4(1.1), carry? All in favour? Opposed? Defeated.

Shall the motion moved by Mr Wilson, 9.4(2.1), carry? All in favour? Opposed? Defeated.

Shall the motion moved by Mr Wilson amending section 9.4(3.1) carry? All in favour? Opposed? Defeated.

The next amendment is a Liberal amendment

Mrs Sullivan: I move that section 4 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.4:

"Restriction on reducing payments, etc

"9.4.1 The minister may not reduce or withhold payments under section 9 or deduct an amount from a payment under section 9.4 if the reduction, withholding or deduction would put a resident's safety, health or security at risk or would cause any of the services or programs in a resident's plan of care to be interrupted."

The Chair: Ms Sullivan, again I must under section 56 of the standing orders rule that out of order because it deals with the funding.

Mrs O'Neill: There are no guarantees in this bill. 1500

The Chair: The next amendment is also a Liberal motion. Miss Sullivan.

Mrs Sullivan: I move that subsection 9.5(2) of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by striking out "classes of persons" in the second line, and I further move that section 9.5 of the Charitable Institutions Act, as set out in—

Mr Hope: Point of order, Mr Chair: Isn't there a Conservative motion that has to be dealt with first, which is 9.4.1? I have a sheet in the Conservative one here.

Mrs Sullivan: Yes, you're right.

Mr Hope: That should be dealt with first, before the Liberal one.

Mr Jackson: You got to bed early last night, didn't you, Randy?

Mr Hope: Oh yes, lots of sleep.

The Chair: I'm sorry. I've got that marked as a Liberal motion. My apologies. Thank you, Mr Hope. Mr Wilson

Mr Jim Wilson: Thank you, Mr Hope. I was kind of enjoying Mrs Sullivan's recitation of "We will return."

Mrs Sullivan: See, now I have to go back to the beginning. You should have let me finish.

Mr Jim Wilson: Well, I was mesmerized by it. I thought it was quite good, because I'll tell you that as to the motion I'm about to put forward, I don't have a lot of hope that it's going to pass.

I move that section 4 of the bill be amended by adding the following sections to the Charitable Institutions Act,

after section 9.4:

"Notice before deduction

"9.4.1(1) Before making a deduction under section 9.4, the minister shall serve on the approved corporation a notice setting out,

"(a) the minister's proposal to make a deduction under section 9.4:

"(b) the proposed amount of the deduction:

"(c) detailed reasons for making the deduction;

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board; and

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the approved corporation at its most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) An approved corporation that is served with a notice under subsection (1) is entitled to a hearing by the appeal board if it mails or delivers to the minister and to the appeal board, within thirty days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If the approved corporation does not require a hearing in accordance with subsection (4), the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) The approved corporation may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal board,

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for the extension; and "(b) may give such directions as it considers proper in light of the extension.

"Hearing

"(7) If the approved corporation requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

- "(9) The parties to a proceeding before the appeal board under this section are.
 - "(a) the approved corporation;

"(b) the minister:

- "(c) the person from whom the approved corporation accepted the payment; and
 - "(d) such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 9.8(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section.

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal:

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to deduct such lower amount under section 9.4;

"(b) may, if the minister has carried out the proposal under subsection (5),

"(i) find that the proposal was reasonable in the circumstances:

"(ii) direct the minister to pay the amount deducted to the approved corporation; or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the approved corporation the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable;

"(c) may substitute it's opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on appeal

"9.4.2 On an appeal to the Divisional Court from a decision of the appeal board under section 9.4.1, the Divisional Court,

"(a) may affirm or rescind the decision of the appeal board;

"(b) may substitute its opinion for that of the minister or the appeal board, and

"(c) may exercise all the powers of the appeal board."

The Chair: Thank you. Any comments?

Mr Jim Wilson: Mr Chairman, almost every witness who addressed the issue of an appeal process during the

public hearings on this bill argued that both facilities and applicants should have access to timely and efficient appeal processes. It has also been rightly argued that this appeal mechanism must be able to address various aspects of the process. Operators must be advised when the minister intends to make a deduction for any reason and, in the interest of keeping the system accountable, this deduction may be able to be appealed. It is through such mechanisms that we are assured that decisions are not being made arbitrarily and that if punitive or corrective measures are being taken, they are warranted.

The Chair: Thank you. Parliamentary assistant?

Mr Wessenger: We'll be voting against this motion on the same basis as previously indicated, that the matter of appeals should be dealt with comprehensively and after consultation in phase 2 of legislation.

Mrs Sullivan: We'll be supporting this, and the arguments have already been put.

The Chair: Shall the motion moved by Mr Wilson carry? All in favour? Opposed? Defeated.

Now that the Chair has found out exactly where we are, I would note that at this point I would move all of section 4, but because there are three amendments that have been stood down, we will have to return to section 4.

We would move on, then, to section 5, and I can return to Ms Sullivan to begin what she had started earlier, with the first Liberal amendment to 9.5.

Mrs Sullivan: I move that subsection 9.5(2) of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by striking out "classes of persons" in the second line

"I further move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Contract for payment

"(2.1) No person or entity may be designated by the minister as a placement coordinator unless a contract has been entered into between the person or entity and the minister on behalf of the crown in right of Ontario and the contract provides for the payment of the person or entity for acting as a placement coordinator."

The Chair: Comments.

Mrs Sullivan: I think the intent is clear. I already note the parliamentary assistant shaking his head. We want to know who is going to hire and pay for the placement coordinators about whom we have no other information, and we feel that there should at least be in the act an indication that the placement coordinator, whether a single person or an agency, is under contract and has to follow the rules of the minister.

The Chair: Thank you. Mr Wessenger.

Mr Wessenger: Yes, we will be voting against this amendment, because the placement coordination is in effect already encompassed in some of the existing non-profit agencies, and I think it would create a degree of problems if this were passed.

Mrs O'Neill: I have a lot of trouble with the notion that it would create a lot of problems just stated by the

parliamentary assistant. I think it would clarify matters. Placement coordination, first of all, is not provided in every community in this province, and where it is provided, it's provided in numerous ways and it is paid for in numerous ways. At the present time, we still don't know—although we've had all kinds of nebulous statements that all these agencies that are there now are going to be grandfathered, we can't seem to get a thing pinned down about this person, body or whatever in this legislation, and it's very discouraging.

Mr Jim Wilson: Mr Chairman, I think those are excellent points. I don't understand the government's reasoning in terms of its saying that this might somehow tick off the VONs or those agencies now providing placement coordination services. I would think it enhances their role and gives them a legislative foothold to ensure that they get paid for the services, particularly the expanded services, that they'll be required to provide under this legislation.

Mrs Sullivan: That's right. There's no downloading, either It's clear.

The Chair: Shall the motion moved by Ms Sullivan carry? All in favour? Opposed? The motion is defeated.

Ms Sullivan, the next amendment is yours.

1510

Mrs Sullivan: Mr Chairman, as I read, I want to draw to the attention of the committee that there will be one word that I'm not reading in which is on the written page in front of you on this amendment.

I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Qualifications

"(2.2) No person or entity may be designated by the minister as a placement coordinator unless the person or entity meets the qualifications prescribed by the regulations."

The Chair: Comments?

Mr Wessenger: Could I ask if the member might be prepared to have this stood down? I think we might be prepared to look at some alternative wording or language.

Mrs Sullivan: I would be very interested in ensuring that there is at least some reference to the notion that placement coordinators should be qualified to do the work they're being asked to do, so I'd be pleased to stand this down.

The Chair: We will stand down this amendment and come back to it.

The next amendment is a Conservative amendment.

Mr Jim Wilson: I'm recovering from the last amendment. It's really quite comforting to know that they won't hire people who don't have some sort of qualifications.

I move that clause 9.5(5)(a) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"(a) within the six months preceding admission, a placement coordinator has determined that the person is eligible for admission to an approved charitable home for the aged; and".

Essentially, this would require a reassessment if the person on the waiting list to enter a facility is on the waiting

list for six months or more. Since the health status of the elderly can change very quickly, it is advisable that a placement coordinator's assessment of the needs of the applicant be made within a six-month period prior to admission. This condition of admission will ensure that the placement is suited to the needs of the applicant and that all of the applicant's needs have been considered.

Mr Wessenger: I'd like to ask Mr Wilson if he'd consider standing it down. I do agree with his comments, but we don't think his motion achieves the desired result and we'd like an opportunity to discuss with him the possibility of achieving it.

Mr Jim Wilson: Okay.

The Chair: So this will be stood down and we'll come back to it.

The next motion is a Liberal motion, 9.5(5.1)?

Mrs Sullivan: Sorry, I have these in my book backwards.

I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended—

The Chair: Sorry. Could I interrupt for a second?

Mr Wessenger: I'm just wondering, should our motion go first?

Mr Jim Wilson: Yes, I think government motion first. Mrs Sullivan: That's why I had them backwards.

The Chair: I apologize. With all these pieces in front of me, I had the Liberal one as next.

Mrs Sullivan: There are three amendments, Mr Chairman, if I could, that may well fold into the government's amendment.

Mr Hope: Are you withdrawing yours?

Mrs Sullivan: Well, we'll just see if the government amendment passes.

The Chair: Would you just allow the Chair a moment here? We can go forward first with the government amendment which deals with a range. I had put it at the end of everything it dealt with, but I'm quite prepared to let that go first, if we feel that would facilitate the discussion.

Mr Jim Wilson: I agree with your suggestion.

The Chair: If everyone agrees, then we'll move to the government's amendment.

Mr Wessenger: I move that subsections 9.5(5) to (8) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Admission

"(5) An approved corporation maintaining and operating an approved charitable home for the aged shall not admit a person unless the person's admission to the home is authorized by the placement coordinator designated for the home under subsection (3), and shall admit a person whose admission to the home is so authorized.

"Applications to placement coordinator

"(6) A person may apply to a placement coordinator for a determination respecting a person's eligibility for admission to an approved charitable home for the aged and, if the placement coordinator determines that the person is eligible for admission, the person may apply for authorization

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of admission with respect to such home or homes as the person selects.

"Assistance

"(7) A placement coordinator who determines that a person is eligible for admission shall, if the person wishes, assist the person selecting the home or homes with respect to which the person will apply for authorization of admission.

"Person's preferences

"(8) In assisting a person under subsection (7), the placement coordinator shall consider the person's preferences relating to admission based on ethnic, spiritual, linguistic and cultural factors.

"Determination respecting eligibility

"(8.1) A placement coordinator shall determine whether a person is eligible for admission to an approved charitable home for the aged only if the person applies for the determination in accordance with the regulations.

"Determination respecting authorization

"(8.2) The placement coordinator designated for an approved charitable home for the aged under subsection (3) shall determine whether to authorize a person's admission to the home only if the person applies for authorization of admission with respect to the home in accordance with the regulations.

"Compliance with act and regulations

"(8.3) A placement coordinator shall make all determinations respecting eligibility for admission and all determinations respecting authorization of admission in accordance with this act and the regulations.

"Conditions of authorizations

"(8.4) The placement coordinator designated for an approved charitable home for the aged under subsection (3) may authorize the admission of a person to a home only if,

"(a) the placement coordinator or another placement coordinator has determined that the person is eligible for admission to an approved charitable home for the aged;

"(b) the approved corporation maintaining and operating the approved charitable home for the aged to which the person's admission is to be authorized approves the person's admission to the home; and

"(c) the person consents to being admitted to the home.

"Approval

"(8.5) An approved corporation maintaining and operating an approved charitable home for the aged shall approve a person's admission to the home unless,

"(a) the home lacks the physical facilities necessary to meet the person's care requirements;

"(b) the staff of the home lack the nursing expertise necessary to meet the person's care requirements; or

"(c) circumstances exist which are prescribed by the regulations as being a ground for withholding approval.

"Written notice

"(8.6) An approved corporation that withholds approval for the admission of a person to an approved charitable home for the aged shall give to the person, the director and the placement coordinator designated for the home under subsection (3), a written notice setting out the ground or grounds on which the approved corporation is

withholding approval and a detailed explanation of the supporting facts."

The Chair: Commentary?

Mr Wessenger: Yes. This is to clarify the intention that the applicant may choose the home to which he or she is applying for admission and that a placement coordinator must consider the ethnic, spiritual, linguistic and cultural preferences of the applicant if asked to assist the applicant in selecting a facility.

It also sets out that the facility may refuse an applicant for admission if the home lacks the physical facilities or the staff lack the nursing expertise necessary to meet the person's care requirements. Also, additional circumstances may be prescribed by the regulations as being grounds for withholding approval. Also, the home must provide the written reasons to the applicant, the director and the placement coordinator as to why the applicant was refused admission.

These amendments affirm the importance of consumer choice in the application process and the duty of placement coordinators to assist applicants in selecting homes based on their preferences. As well, they will address the request by facilities that the grounds for refusal of admission that will be permitted will be dealt with explicitly in the act.

The Chair: That covers a number of areas, so I'll allow the discussion to cover, perhaps, some of the other amendments that have been proposed that deal with some of the same areas. We'll begin with Mrs Sullivan.

1520

Mrs Sullivan: This motion is indeed almost all-encompassing with respect to the eligibility admissions process. I have two or three comments. Some of the changes here I see as significant improvements; I should say that.

First of all, under "Admission," under subsection (5), we see in the second-last line that the home "shall admit a person whose admission to the home is so authorized" and yet laterally, of course, the home can withhold approval. I'm wondering if we shouldn't change "shall" to "may" so that everything falls into line.

I'm concerned, under subsection (6), "Applications to placement coordinator," that this section will mean that in fact there are two applications which must be made by the resident, the first with respect to eligibility and the second with respect to a specific home, rather than one application where the placement coordinator both determines eligibility and takes into account the preferences and the assessment.

Under "Person's preferences," with the ethnic, spiritual, linguistic, cultural factors—we all wanted that. It was clear that this has been put forward in the amendments proposed by both of the opposition parties, and we're pleased with that.

"Determination respecting eligibility" and "Conditions of authorization": I am concerned and my party is concerned that there is no indication in the act itself of which factors must be taken into account by the placement coordinator in determining the eligibility for admission. So, by example, we have had a strong indication that there should be an assessment of the impairment and capacity of the person. Those would be done by the professionals who are able to do that, and yet that is not included in this section

of the bill, nor is it included anywhere else in the bill. We feel that's an omission that ought to be added to this or another section

We are pleased that the government has recognized that there is a difference in the facilities and in the staffing available in specific homes and that this has been recognized under the "Approval" section.

We are disappointed, along with, I think, both the charitable municipal and private sector homes which appeared before us, that the government has not indicated that it would accept that the placement coordinators should be looking at a priority level for admission. Given that the home itself has very little control over the acceptance of a potential resident once the placement coordinator has determined eligibility for admission, it appears that the onus is then on the home to determine what priority the resident should be accepted in, despite the need for his admission at a particular time. So the time line then becomes the determining factor as to whether the person would be admitted.

I'm just glancing ahead at various amendments that we have put. Many of our amendments are covered here, but I still do have reservations and hope the government would look at accepting some amendments in those areas.

The Chair: Before moving to the parliamentary assistant, Mr Wilson, did you wish—

Mr Jim Wilson: Maybe we should hear from the parliamentary assistant. I have a rather lengthy discussion to begin here, Mr Chairman.

Mr Wessenger: I think one of the items raised by Ms Sullivan perhaps ministry staff should respond to.

Mr Geoffrey Quirt: Geoff Quirt, acting executive director of the long-term care division.

I can clarify that there would be one application process through which an applicant would have his or her eligibility determined and at that time would select the facility or facilities of his or her choice. The placement coordinator would be required, if asked, to provide advice to the client to help the client in the selection of the facility and would be required to provide that advice, taking into account spiritual, linguistic and ethnic considerations.

I'd further clarify that it would be the responsibility of the placement coordinator to determine priority for admission among all those applicants who had made an application to a particular facility. They would be required to authorize admissions for emergency situations first, and then among non-emergency applications, the person's time of application and the chronological order would apply as to when someone would gain admission to the facility. So there's one application process where clients choose the facilities they wish to be admitted to and the placement coordinator then determines priority based on the needs of the client group.

Mrs Sullivan: In that case, I would suggest that we do need an amendment or a change in the drafting to subsection (6), which clearly provides for two applications: "may apply" for eligibility, and if eligibility is concurred with or agreed to, the person "may apply" for admission. That must be changed. If that is not the intent—certainly, we do

not think it's the appropriate way to go—that wording must be changed.

Mr Wessenger: I'll ask legal counsel to clarify that.

Ms Czukar: It is our view that's what subsection (6) says. It says that a person may apply to a placement coordinator for a determination respecting eligibility to a home, and if eligible, the person can apply for authorization of admission. All of that can be done in one process, but the eligibility has to be determined first. This doesn't really detail the admission process or the application process so much as the order in which determinations have to take place. Authorization of admission only occurs after all these other things have happened, but the application for admission can happen at the same time as the application for eligibility.

Mrs Sullivan: I believe this wording indicates there are two specific and separate applications. We will be very amenable to a friendly amendment if the legal beagles can put their minds to it. Anybody who is reading this for understanding about what they must do in order to apply for a home will read this and understand that there are two applications which must be made, and maybe in two different locations.

Mr Jim Wilson: I have four amendments tabled that deal with—

The Chair: I'm sorry, just so we're clear, those four amendments are the ones that are presented already. You haven't orally presented them, but the ones that are in our bundle.

Mr Jim Wilson: Exactly. They deal with aspects of the government's amendment. First of all, I just want to say about the government's amendment that's been read into the record that I'm pleased the government appears to have come a long way from where we were a few weeks ago when we were talking about placement coordination and eligibility. I think the government's amendment clarifies the role of placement coordinators somewhat. I'm pleased to see that it requires a person's consent prior to admission and that it acknowledges the ethnic, cultural, spiritual and linguistic preferences of consumers.

I note where a person's preferences in subsection (8) were outlined, we don't consider social factors, which is something that is very much a part of the fundamental principles section of the bill.

1530

I do admit and am pleased to see that the government's amendment does allow for some grounds for refusal by homes for admission to homes. I would just ask committee members to consider for a moment the PC amendment of subsection 9.5(6), which talks about further inclusion, in the bill, of grounds on which a facility may refuse an admission. I think one of the chief criticisms of Bill 101 that we heard from witnesses is that so much of this bill is left to regulation. I think in the interests of patients, residents and providers, the grounds on which a facility may refuse an admission must be clear. This amendment seeks to do that, to delineate some grounds so that everything isn't left up to the regulations. I think this amendment serves the interests of the consumer because it will put an

onus on the placement coordinator to consider the special needs of an applicant who has been refused admission by a facility and seek a placement more suited to his or her needs.

So I just ask the government to keep that in mind for a moment and to also take a look at the next PC amendment. which is 9.5(7.1). I'm mindful that perhaps some of the numbering of these amendments would have to be changed if the government felt they were useful amendments. That amendment deals with health status. It asks that placement coordinators be sure to take into account all aspects of a person's health, that these aspects must be considered when a placement coordinator is making a determination and, as well, by requiring "a full account of the person's health status," consumers are ensured that their physician has played a role in bringing the applicant's special needs to the attention of the placement coordinator. That was something that was brought to our attention by the medical profession and by a lot of other groups that wanted to know who was doing the pre-admission assessment and what aspects would be considered therein. So this is an attempt to ensure that isn't totally left up to regulations.

If I may, Mr Chairman, the big amendment of the PC motions is subsection 9.5(8); it's the largest one. It attempts to set up a priority rating system, which I was hoping the government would take a very close look at, because we put in a lot of time and effort and had a lot of consultation with respect to this. Members can read through that motion. We've proposed the inclusion in this amendment, in order to address recommendations particularly dealing with veterans and spouses, the assignment of a priority rating, a process which is being discussed, actually, in the draft manual that the ministry has put out.

At the same time as the termination on eligibility process, the consumer will know exactly where he or she stands in relation to others looking for similar services. Priority ratings will be subject to appeal so that in the circumstance that someone's needs have changed or the placement coordinator has overlooked or underjudged the relevance of some factors, the consumer will have access to a system that can have his or her situation re-examined.

Our amendment ensures the flexibility and responsiveness of this critical first stage of the long-term care system, ie, the placement. It goes on. Not to belabour the points in the amendment and the benefits thereof, but we assign a very high priority to spouses. If your partner is already in a home, we believe the priority rating system should take into account and give a high rating to the spouse seeking to enter the home.

Secondly, in that amendment we deal with a priority rating for veterans, because I don't feel that a letter from Ruth Grier is really worth all that much in court. In fact, it's kind of a nice political letter that the parliamentary assistant has put out, where the onus is now back on Kim Campbell, the federal minister. I'm a former executive assistant. I used to draft those letters and I know exactly what we're doing there. You can't take that stuff to court, whereas you can take a piece of legislation to court.

I would be interested to hear the parliamentary assistant's comment on the priority rating system that we're

attempting to set up here, because we think it catches and deals with a lot of the problems. I simply don't want to hear the tape-recorded message that we're not accepting this amendment. Perhaps we could have something a little more in-depth than that from the parliamentary assistant.

The last comment is important because it's subsection 9.5(8.4), a PC amendment. It's an alternative plan of care. There was some discussion with Mr Quirt that perhaps the government was interested in accepting this amendment. If they are, or some variation thereof, then we better hear that now before we vote on this whole thing.

The Chair: Really then, just to underline in dealing with the government amendment, the questions that both you and Ms Sullivan have posed relate back to your amendments and to what extent the government is prepared to accept some or all cooperative changes, what have you.

Mr Wessenger: To give some indication with respect to the amendments proposed, first of all by the Conservatives, the first one, I think I can give you an indication with respect to 9.5(6), which sets out grounds for refusal, (a), (b) and (c) would make a person not eligible for admission to a long-term care facility, they're set out so they're unecessary, and (d) is considered too vague and (e) is already covered. For that reason, we'll not support that and we'll not be voting for that amendment.

The next one, subsection (7.1), I believe there is a Liberal amendment which might be amended which might be workable, so I think that probably should be—

Mr Jim Wilson: Could we take these one at a time? **The Chair:** Why don't we just have him comment?

Mr Wessenger: I'm just indicating that there's a Liberal amendment that we might be able to work with that would supplant that.

The Chair: So we have an indication there may be some change with that (7.1). Okay, go ahead.

Mr Wessenger: With respect to 9.5(8), we will not be supporting it, although I understand there is an amendment under discussion.

Interjection.

Mr Wessenger: The veterans' one we're going to—

Ms Czukar: Oh, 9.5(9.1)? We'll discuss that first.

Mr Wessenger: Yes, (9.1) we'll be discussing.

Interjection: Point of order, please.

The Chair: Would it help if we had just a few minutes recess to see where there may be some agreement here, because I sense we're starting to run around a little bit and we may advance the cause. It is 20 to 4, if I might suggest a 10-minute recess.

Mr Wessenger: Yes.

The Chair: Okay? We'll recess then for 10 minutes.

The committee recessed at 1538 and resumed at 1553.

The Chair: We will reconvene. There has been much discussion during our 10-minute recess and I'll turn to the parliamentary assistant to give us some sense of where we're at.

Mr Wessenger: I believe we're working on some amended language to subsection (6) of the government

amendment, but we haven't got legislative counsel—oh, I think we have. Okay. If I might read in—

The Chair: Just for everybody's attention then, we're dealing with subsection (6) of the government amendment.

Mr Wessenger: Yes, and what we're asking for is a friendly amendment to delete subsection (6) as it now exists and read in as follows:

"(6) A person may apply for a determination by a placement coordinator respecting the person's eligibility for admission to an approved charitable home for the aged and for authorization of admission with respect to such home or homes as the person selects."

If I could just hand this to-

The Chair: I feel like I'm being given an award.

Mr Wessenger: Then we have a second amendment.

Interjection: Do we have to vote on that one first?

The Chair: No, we haven't voted yet, so do you want to continue with the next one? I'll just get these down.

Mr Wessenger: Yes, the next friendly amendment is on page 2, (8.4) and (8.4)(a), and after "coordinator has determined," we're going to add in the words, "within the preceding six months," so it reads as follows:

"The placement coordinator or another placement coordinator has determined, within the preceding six months, that the person is eligible for admission to an approved charitable home for the aged."

The Chair: Has everyone got those two amendments? I can repeat them if you'd like.

Mr Jim Wilson: On the latter, just tell me what you're deleting out of subsection (6), because all it sounds like you did was—

The Chair: All right. Let me go back to (6) then. Subsection (6) reads, "A person may apply"—and then take out "to a placement coordinator." So it would be, "A person may apply for a determination by a placement coordinator respecting the person's eligibility for admission to an approved charitable home for the aged and"—and then we would delete the following—"if the placement coordinator determines that the person is eligible for admission, the person may apply." All of that is deleted, so after "and" it would read, "for authorization of admission with respect to such home or homes as the person selects." Just to make it crystal-clear, I'll read it as now amended.

"Applications to placement coordinator

"(6) A person may apply for a determination by a placement coordinator respecting the person's eligibility for admission to an approved charitable home for the aged and for authorization of admission with respect to such home or homes as the person selects."

Then, on page 2, (8.4)(a): "The placement coordinator or another placement coordinator has determined, within the preceding six months, that the person is eligible for admission to an approved charitable home for the aged."

So in that one, we've simply added those words. Mr Wilson.

Mr Jim Wilson: On the latter amendment, "has determined within the previous six months"—

The Chair: I'm sorry, "within the preceding." Did I

Mr Jim Wilson: "Preceding six months." Preceding what? The determination of eligibility or the authorization of admission?

Mr Wessenger: Preceding the authorization.

Mr Jim Wilson: Yes. Preceding the authorization of admission. Is that implicit in the way you've reworded that?

Mr Wessenger: It is, because it's in that.

Mr Jim Wilson: Okay.

Mrs Sullivan: Mr Chairman, with respect, I don't think this does what the third party wanted it to do. What the third party wanted to have assurance of is that there is a reassessment of the applicant's eligibility for admission and of the determination of the authorization of admission every six months. I don't think this does it. Right?

Mr Jim Wilson: Mrs Sullivan is very much correct but not wholly correct, in that our problem with the drafting was finding a reference point for the six months. I do accept the advice that's been given that it has to be six months preceding the authorization for admission, otherwise—I guess I didn't realize, in drafting this, that we wouldn't have any clear idea of what the date of admission would be. That was kind of an omission on my part. If there aren't any other comments from the government, I'd accept the new wording.

The intent is, of course—now, anyone else can throw in any ideas they may have, but—

The Chair: I think there is perhaps a comment that may deal further—

Mr Wessenger: Just to clarify, perhaps we should say, "The placement coordinator or another placement coordinator has determined, within the six months preceding authorization," and then it's completely clear.

The Chair: Again, that's for (8.4). I wonder if this is agreeable. I would like to put this amendment, and we will then go back to the other ones and either deal with them or not to the extent that they have been included.

1600

Mr Jackson: Mr Chairman, on a point of clarification: You're amending Mr Wessenger's motion, so it's an amendment to the amendment.

The Chair: It is an amendment to the amendment.

Mr Jackson: So we're still on the main amendment, once it's approved for amendment?

The Chair: Yes.

Mr Jackson: Thank you. Could you please reword it properly, (8.4)?

The Chair: Clause 9.5(8.4)(a) would then read as follows:

"The placement coordinator or another placement coordinator has determined, within the six months preceding authorization, that the person is eligible for admission to an approved charitable home for the aged."

If I could then ask, shall Mr Wessenger's motion, as amended—

Interjection.

The Chair: Let me put it this way. Mr Wessenger, perhaps we could do it that you have removed your original motion and are now moving the motion as amended.

Mr Wessenger: Yes, okay.

Mr Jackson: The amendment as amended. I'm sorry, I wish to propose—

The Chair: He has withdrawn the original one, so you're right in describing what we're doing.

Mr Jackson: —to put in the motion, because I have a further question and I have a further amendment to subsection 9.5(5).

The Chair: Okay. Just so we're clear, and I appreciate the point you're making, Mr Jackson, with the two changes—let me call them that—we have made to the original amendment, Mr Wessenger then has withdrawn his amendment and it has come back with the two changes we had discussed, so that is now his amendment. You now wish to ask a question and to have us consider an amendment or two to that. I recognize you.

Mr Jackson: Thank you, Mr Chairman. In subsection 9.5(8), "Person's preferences," could the parliamentary assistant advise if his interpretation of "linguistic" includes the presentation we received from the Bob Rumball Centre for the Deaf, where the deaf and non-sighted community indicated that they had a linguistic concern, that they had linguistic rights in Ontario, that they did not feel they were handicapped, that they were differently abled from you and I linguistically. Is that the interpretation, for the record?

Mr Wessenger: I would interpret it as being definitely included either in the word "linguistic" or "cultural," because I think it might be indicated they indicated that cultural was more of their—

Mr Jackson: Okay. My second question then is, has the government in any of its motions, since you're going to come back to those, I understand, that are being proposed by both opposition parties, made any direct reference to matrimonial factors or familial factors. If you're silent on spousal access, it would appear that this is the clause where you could include that, because matrimonial or marital or familial, which is a sole surviving senior but who has supportive family members in a given community, would constitute grounds for placement since there would be additional support services around a senior because of familial concerns.

Before we pass this complete motion, this is an opportunity to include those two further conditions, to the benefit of seniors. It might be more appropriately placed here, if the government is looking favourably upon matrimonial or familial factors for placement.

Mr Wessenger: I'm going to ask ministry staff actually to clarify with respect to how they are going to deal with these two items you've raised. I believe it's going to be dealt with in regulations, but I would like them to comment.

Mr Quirt: The issue of a spouse wishing to accompany his or her spouse into a long-term care facility will be dealt with in the eligibility criteria. As I read the amendment proposed by your party, the amendment would be restricted to providing priority to eligible applicants to

long-term care facilities with respect to their being able to have a higher priority to get into the facility of their choice where their spouse resides. In our eligibility criteria, we're looking at the issue of considering admission for non-eligible spouses if they should wish to accompany their spouse into a long-term care facility. In those discussions we're considering a broader exemption for spouses, and we are currently organizing a work group with providers and consumers to look at ways in which the eligibility criteria might account for spouses being able to accompany an eligible resident into a facility.

Mrs O'Neill: Do we have the actual part of the act where that is going to be attended to so we could watch for it if it's coming up?

Mr Wessenger: It's not going to be in legislation.

Mrs O'Neill: It's not going to be in legislation; okay.

Mr Wessenger: It will be in regulations. These are very difficult items, this whole question of eligibility, I think it's fair to say, and I think it's also fair to say that by keeping the eligibility in your regulations, you're going to provide your flexibility to ensure that you appropriately deal with situations and not have a rigid system that would require an amendment to the act. I think it's very important that we preserve the flexibility, in this case in the eligibility area, so we can ensure we don't find the legislation in a bind, in an inappropriate situation.

Mrs O'Neill: I'd like to just pursue that one.

The Chair: I'm sorry, Mrs O'Neill. Mr Jackson hadn't finished.

Mrs O'Neill: It's on that very item.

The Chair: I believe he's on the same item, if we could just let him finish, and then I'll come back to you.

Mr Jackson: If I heard Mr Quirt correctly, he indicated that the matters raised in a Conservative amendment would be considered. He did not indicate that they would seek favourable support by the government. Am I to further understand that they might seek favourable support in the form of a regulation? If that is the case, then I certainly would like to propose an amendment which would indicate—there are two issues here. One is that the placement coordinator would be sensitive to this matter in terms of a placement where primacy is not an issue. Then the second issue, which the Conservatives address in another amendment, deals with priority, I should say, not "primacy," but "priority" for a spousal application. What I'm simply suggesting is that a person's marital status should have as much importance and weight in legislation as his language or his spiritual needs.

I see no reason why the government should avoid its inclusion in this section, because we're dealing with the sensitivity of the placement coordinator in considering these matters for placement. We'll deal with how much importance they place on them, but in this section they're not required in law, and the way the law works, Mr Chairman, as you well know, is that because it's not included, it therefore is not deemed to be a considered matter. If it appears in regulation, it can disappear in regulation. So I

think the aspects of marital status and being close to a spouse in an institution is important.

I also believe, if legal counsel can guide us, that the phrase "familial," which is proximity in matters dealing with the proximity of family members, which could encompass a larger support network for a senior, not just the spouse but having grandchildren or a daughter or a son nearby, would be helpful to the process of seniors' long-term placement, and those should be considered.

I notice that the Liberals have also included the reference to geography. Not to clutter this, again, once we've passed this motion, we've closed the door to amending it any further. Before we do that, I want to make sure we have a full discussion on these points, because this is the section, in my view, which should include the matters for consideration by the placement coordinator.

The Chair: Before asking the parliamentary assistant to respond, Mrs O'Neill, because you're on the same subject, do you want to comment?

Mrs O'Neill: Yes. I wanted to go back to something that legal counsel said this morning, that the service agreement would be interpreted according to the bill of rights. That was the context or the backdrop. I wanted to know if these regulations that are out there, some day to be discovered, are going to also be developed around the backdrop of the residents' bill of rights. That's my first question.

1610

Mr Wessenger: If I remember the language correctly, it does refer to the guide and interpretation of the regulations of the bill of rights. I think that's correct. It doesn't refer to placement coordination, of course.

Mrs O'Neill: This is a matter that came before us several times. If I just might comment on that last comment of Mr Jackson's, one of the government amendments that I think was handed out this morning was talking about the appeal board and three people and that at least one of these would be resident near or in proximity to the home. To me, if the appeal board members should be, then we should know something about the actual residents as well, in reference to geography. I want to just preliminarily say I really support that this be included somewhere, as well as the "cultural, spiritual" language that we've been talking about up till now. Geography should be included in that same set of guidelines.

The Chair: In trying to be helpful with some of the points that have been raised here, and noting that there is some to and fro around drafts and so on, with respect to this amendment, as has been suggested by a number of the opposition members, would it be helpful to stand this down and return to it first thing in the morning or are you able to deal with it now? I think we need to come to some conclusion or else defer it.

Mr Wessenger: I think we should proceed, actually.

The Chair: All right. Would you respond to the points that Mr Jackson and Ms O'Neill have raised.

Mr Wessenger: I understand the point Mr Jackson is making, but the way I read subsection 9.5(8) is that the priority element with respect to what the placement

coordinator must take account of is the person's preferences, and that has to take primacy, as I've indicated. The indication of the words, "ethnic, spiritual, linguistic and cultural factors" was to direct the attention of the coordinator to those items to give assurance to groups that had appeared before us which were concerned that there would be a lack of attention to those factors.

But I suggest that the overriding preference aspect would take into account the family situation, because that would be incorporated under the preference, as would geography. Practically everything is incorporated under preference. Delineating the additions is really to draw attention rather than to determine the decision, because the decision is the person's. Rather than the placement coordinator, it's the person who is making the choice of where he is going to go. My concern is that we will get a never-ending list of things. We could add a hundred items to this section, and that's my concern.

The Chair: I have two questioners, Ms Sullivan and Mr Wilson.

Mrs Sullivan: I wonder if we couldn't look at a friendly amendment here, in the second-to-last line of subsection 9.5(8): "consider the person's preferences relating to admission, including ethnic, spiritual, linguistic, cultural and other factors." Then the list doesn't have to go on for ever and ever.

Mr Jim Wilson: Just to add to that, I felt very strongly that there was agreement that spouses should be able to follow spouses. I recall being told by the government that it was such a small percentage of cases where a spouse would actually want to follow a spouse that it wasn't a big deal to include this language in the legislation. Rather than leave spouses—who are rather important in our society and should be more important to the government—in the "other factors" category, I think Mr Jackson's right: It's just as important as spiritual, linguistic and cultural factors for many, many people.

The Chair: Just so I understand, are you suggesting to add there the word "familial" or some such word?

Mr Jim Wilson: If we could get a suggestion from the legal beavers, it'd be helpful.

The Chair: While that is being done, Ms O'Neill had a comment as well.

Mr Jim Wilson: We'd do "marital," but I'm not sure what the Liberal Party means by "marital" any more, given last week's press release.

Mrs O'Neill: I feel very strongly about both of these. It isn't as though we've got a list of 50. We've all been working on this for almost six weeks, this group here, and many people have been working on this for six years. The things we've come up with that are not stated are "familial" and "geographic."

I'm sorry I made a mistake earlier; I had mixed up "appeal board" with "residents' council." It's in the residents' council amendments of the government that "only a person who lives in the area in which the approved charitable home for the aged is located and who was not employed by and does not"—that's who the minister may

appoint to a residents' council. If it's so important that an appointment to a residents' council have some knowledge of the location of the home and the needs of that community, then I think it is important for the people in that community to have some security that that is the community which will continue to care for them, as it has all their lives.

We heard that particularly from rural Ontario and in the north. We were told, if I recollect correctly, by the native people that the length of stay in long-term care facilities that are out of their neighbourhoods is exactly six months: People die, because they are moved from all the support systems they have.

The familial and geographic are, for me, very key components of continuum of care. I don't think it would hurt anyone if you want to then add "and all other things" that the next generation may think up; I could go with it. Are we for trying to preserve as much of a family and quality of life as we can for our seniors? That's what I want to know

The Chair: Just to try to bring this into focus, Ms Sullivan has suggested adding the words "and other." Mr Wilson and Ms O'Neill have indicated that they would still like to see the words familial" and "geographic," and Mr Jackson mentioned "spousal." I'm talking because I know learned counsel is trying to come up with some words.

Mr Jackson: Mr Chairman, to be helpful, can I propose an amendment to the amendment? Then we can deal with it directly, as opposed to falling back into a negotiating mode here. I'll be guided by you.

The Chair: The government has a proposal to make. Could I perhaps ask them to—

Mr Wessenger: We don't.

The Chair: No, sorry; they don't.

Mr Jackson: I still asked for a legal definition. Is there a proper legal definition for "familial" and does that include all family members; that therefore spouse is included? Then I'd be satisfied with "familial." It has to be in the same language intent. Could I get a legal opinion as to the interpretation of the word "familial," or the preference for "matrimonial" or "marital"?

Mr Wessenger: I've asked for a legal opinion. I don't know whether I should give it to legislative counsel or to—

Mr Jackson: There's a room full of lawyers here. Somebody please speak up. They're not charging for it, obviously.

Mr Jim Wilson: Not by the word.

Mr Wessenger: I think this is a question for the drafters.

The Chair: Would you first identify yourself?

Mr Mark Spakowski: I'm Mark Spakowski with legislative counsel's office. The word "familial" would just have its ordinary meaning in that case. In the context, I think it would have a very general meaning and would probably encompass all sorts of relations that are family-like: spouses or other relations.

Mr Jackson: Thank you. Then, Mr Chairman, I would like the government, in an overwhelming spirit of cooperation, to—I know Mr Wessenger's married, and I'm

sure he sees the value in the suggestion made; he has children and sees the value in the suggestion being made; and God knows, he probably has older persons in his family he would like to be close to and accessible to in their declining years. Would Mr Wessenger include the word "familial," which is interpreted now to include "spousal," as a consideration only? My God, we're not talking about etching the primacy of it in this section; we're just saying it has to be included.

1620

Mr Wessenger: I think I might be prepared to consider that as an amendment, on the basis that perhaps I—

Mr Jackson: Have to see your mother later this month or something.

Mr Wessenger: I have some sympathy for that amendment.

The Chair: Can I just ask, in terms of our procedure, whether Mr Jackson wishes to move that as an amendment.

Mr.Jackson: Yes.

The Chair: The other approach is that the government may be prepared to accept it; we can just encompass that along with the other two we've already made, and then we have the one motion, okay?

Mr Jackson: In the interests of time-

The Chair: In the interests of time, if I can be guided by the parliamentary assistant, then in (8) under "Person's preferences" it would read, "In assisting a person under subsection (7), the placement coordinator shall consider the person's preferences relating to admission, based on ethnic, spiritual, linguistic, cultural and familial factors"?

Mr Jackson: A great alliteration, but no.

Mr Hope: You should put "familial" before you put "cultural factors." It should come before "cultural factors" or it's a different terminology.

The Chair: So it would read, "In assisting a person under subsection (7), the placement coordinator shall consider the person's preferences relating to admission, based on ethnic, spiritual, linguistic, familial and cultural factors." All right? With that, may I put the motion?

Mr Wessenger: We would like to add another amendment to this, to 9.5.

I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Assessments etc to be taken into account

"(8.3.1) in making a determination respecting a person's eligibility for admission, a placement coordinator shall take into account any of the following which are provided to the placement coordinator:

"1. an assessment of the person made by a health practitioner relating to the person's impairment or capacity;

"2. an assessment or information relating to the person's requirements for medical treatment, health care or personal care."

The Chair: Just to be clear, what you have added into yours I will term a friendly amendment to Ms Sullivan's proposal.

Mr Wessenger: Yes.

The Chair: Okay. Has everyone followed that?

Mr Hope: Got it. Let's move on.

Mrs Sullivan: I think this is an important amendment, and clearly this is one I would have put in any case, because it will involve the professional assessment with respect to impairment or capacity and any other information that is necessary in determining the plan of care or placement. I think it's an important amendment.

The Chair: May I now put Mr Wessenger's motion, and in putting that, all of those changes we have proposed that are part of it? All in favour? Opposed? Carried.

This is historic, I think. Just so we understand, that amendment is then accepted.

The Chair: With the help of both Ms Sullivan and Mr Wilson, we will go back from whence we came: Those that have been covered we can deal with, but if there are some there that are still dealing with other issues, we will of course deal with them.

I had next on my list the Liberal amendment, subsection 9.5(5.1).

Mrs Sullivan: That motion was included in the government amendment.

Mr Hope: On a point of order, Mr Chair: Because the motion that was just passed covered from 9.5(1) and went through, does that then make these motions that the Conservatives and the Liberals have put forward obsolete?

Mrs Sullivan: No. That's what we're doing now.

The Chair: Some of that had been covered, but there were some things that they may still want to move.

Mr Hope: Then I am asking a procedural question. We had an act; we amended it with a government motion. Now we're going to amend the government motion even further?

The Chair: We have agreed, but they may move other amendments if they wish.

Mr Hope: That's the procedural question I'm asking.

Mr Wessenger: Maybe I could interject. I think we agreed to proceed with our motion first, although technically it was not the first motion. By agreeing to proceed with our motion first, we have to allow the opposition its amendments.

Mr Jim Wilson: It doesn't make the others null and void.

The Chair: Ms Sullivan, if you would proceed.

Mrs Sullivan: The first amendment I have proposed to section 9.5 of the act, with respect to consent, is included in the government amendment, so I will not place that.

The Chair: All right. Mr Wilson, the next one was your subsection 9.5(6).

Mr Jim Wilson: Mr Chairman, I won't introduce it, given that Mr Wessenger, in his comments much earlier, indicated that (a), (b), (c) and (d), which talk about ventilation, onsite surgery and epidural anaesthesia, would make a person ineligible in any case. I won't be introducing that.

The Chair: Okay. Ms Sullivan, you had an amendment, subsection 9.5(6).

Mrs Sullivan: Yes, it's comparable. The last section is of course covered in the government amendments. The first three are with respect to ventilation therapy, onsite surgery and epidural anaesthesia.

I want to put on the table why this amendment was there, although I understand that the government will not accept it. It has been placed at the request of homes themselves, who want the bill to be more specific about what in fact they will be required to provide services in.

It's one thing for us to hear from the parliamentary assistant that these procedures would make the person ineligible for admission. That doesn't appear anywhere, and there is no indication other than that assurance from the parliamentary assistant that that's the case.

The Chair: So with those comments we'll move on. You had the next one, subsection 9.5(7).

Mrs Sullivan: This amendment is with respect to a priority level. I will not proceed with that.

The Chair: Mr Wilson.

Mr Jim Wilson: The amendment dealt with health status, and I believe that with the Liberal amendment to the government's amendment regarding assessments, it's sufficiently covered and I won't introduce that amendment.

The Chair: Thank you. Ms Sullivan.

Mrs Sullivan: Subsection 9.5(7.1) with respect to assessments was covered with the most recent government motion put forward.

The Chair: Thank you. Mr Wilson.

Mr Jim Wilson: Subsection 9.5(8). Mr Chairman, I'd like, with the committee's indulgence, to read that into the record.

1630

I move that subsection 9.5(8) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Priority and authorization

"(8) Subject to subsection (10), if the placement coordinator designated for an approved charitable home for the aged under subsection (3) receives an application, made in accordance with the regulations, for authorization of a person's admission to the home, the placement coordinator shall assign to the person a priority rating and, taking the priority rating into account, shall determine in accordance with the regulations whether to authorize the person's admission to the home.

"Assigning priority rating

"(8.1) The priority rating assigned to a person under subsection (8) shall be based on the immediacy of the person's need for admission relative to the immediacy of the need for admission of the other persons applying for admission.

"Priority rating for spouse

"(8.2) Despite subsection (8.1), a person applying for admission to an approved charitable home for the aged in which his or her spouse is resident shall be assigned for the purposes of admission to the home a priority rating that is

higher than the priority rating assigned to the applicants for admission to the home who do not have spouses resident in the home.

"Priority rating for veteran

"(8.3) Despite subsections (8.1) and (8.2), a veteran applying for admission to an approved charitable home for the aged that receives or has received financial contributions from the Royal Canadian Legion shall be assigned, for the purposes of admission to such homes, a priority rating that is higher than the priority rating assigned to non-veterans applying for admission to such homes."

I think a number of the points have been made in comments previous. To summarize, the intent of the amendment was to set up a priority rating system that would recognize the right of one spouse to join a spouse who is currently residing in a home and, secondly, to ensure that the rights respecting a veteran's priority admission and access to homes are respected. Having said that, I'll be withdrawing the amendment.

The Chair: The next two were Liberal amendments.

Mrs Sullivan: The preferences and requirements of persons have been covered.

The Chair: You had the next one.

Mrs Sullivan: The limitation section with respect to care and services which can be provided at the home is covered.

The Chair: Mr Wilson, the last one on this list prior to the government one was yours.

Mr Jim Wilson: That has also been incorporated into the government's amendment dealing with this subsection, (9.5). Further to my comments about veterans and spouses, I hope that by saying I'm withdrawing that previous PC amendment it didn't leave the impression that we didn't try every avenue available to us to try to ensure that the government respected the rights of veterans and spouses. I just want to make sure that's clear.

The Chair: The parliamentary assistant wanted to clarify something with respect to your motion.

Mr Wessenger: Mr Wilson, I wanted to indicate to you that your motion has not been included. That's why I'm wondering whether you really want to consider withdrawing it.

Mr Jim Wilson: You're absolutely right, Mr Wessenger. I thought we were dealing with the six-month review of the—

Mr Wessenger: No.

Mr Jim Wilson: Okay. I will move this motion then, Mr Chairman.

The Chair: Please go ahead.

Mr Jim Wilson: I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection after subsection (8.3), and I'd ask members to follow along in the wording because I'm changing the wording slightly:

"Alternative plan of care

"(8.4) A placement coordinator shall suggest alternative services or make appropriate referrals"—

Mr Wessenger: Sorry, would you please say that again?

Mr Jim Wilson: "A placement coordinator shall suggest"—we strike the word "an"—"alternative" and add "services or make appropriate referrals on behalf of an applicant if". So we're striking "plan of care," too.

Mr Wessenger: So that would read, "A placement coordinator shall suggest alternative services or make appropriate referrals on behalf of an applicant if"?

Mr.Jim Wilson: Yes.

"(a) the placement coordinator determines that the applicant is not eligible for admission to an approved charitable home for the aged; or

"(b) the placement coordinator determines that the applicant is eligible for admission to an approved charitable home for the aged but does not authorize their immediate admission."

Mr Chairman, the intent, of course, is to ensure that families and potential residents are not left in limbo, that the placement coordinator take on the additional responsibilities of suggesting community services that might be available when a person either is not yet eligible to go into a home or hasn't got a home to go into.

Mr Wessenger: I think I'd suggest one friendly amendment. "A placement coordinator shall suggest alternative services for"—the word "for" should be added.

I'd also like to ask legislative counsel, I think, if this is the right place for this amendment.

Mr Jim Wilson: In terms of numbering?

Mr Wessenger: Yes.

Ms Joanne Gottheil: We'll have to change it because there already is an (8.4). I just have to determine where it should go.

Mr Jackson: You have a standard clause at the end of the activity to adjust the numbering in accordance, so that would be covered. Why don't we proceed on that basis?

The Chair: I was just going to say, if that is at issue, are you saying you accept that?

Mr Wessenger: Yes, as long as this is adjusted.

The Chair: Legislative counsel, is that acceptable?

Mr Spakowski: You can suggest numbering.

The Chair: Okay, we can suggest numbering, so—

Ms Gottheil: It's probably (8.7). It goes at the end of the—

The Chair: Okay. Then may I put the question that the motion, the friendly-amended motion of Mr Wilson, is accepted? All those in favour? Opposed? Carried.

Our next amendment is a Liberal amendment. Ms Sullivan

Mrs Sullivan: Mr Chairman, I have a motion in front of you with respect to preference for veterans in veterans' homes. I redrafted that in longhand and don't have a copy of that to read into the record.

I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Preference for veterans in veterans' homes

"(9.1) In making determinations under this section, placement coordinators shall authorize priority access to veterans in approved charitable homes for the aged in which beds have been designated through a federal-provincial transfer agreement for veterans."

I think we know what the issue is. I'm prepared to stand this down for now to work on other wording, but I did want to bring it into the record.

The Chair: There is a suggestion that it be stood down. Is this agreeable?

Mr Wessenger: Yes, it's agreeable.

The Chair: Okay, then we'll stand that down. Ms Sullivan, you have the next amendment.

Mrs Sullivan: I move that section 9.5 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Preference for persons discharged from facilities

"(9.2) In making determinations under this section, placement coordinators shall, subject to subsection (9.1), ensure that preference is given to persons whose discharge as a resident was authorized under section 9.7.2, section 19.1.2 of the Homes for the Aged and Rest Homes Act or section 20.3.2 of the Nursing Homes Act."

This is one of a series of amendments with respect to the discharge and transfer of a resident from a facility which can no longer care for that person. There's a series of amendments that would be put, and I have just received them from legislative counsel. The next series hasn't been circulated. How should we proceed?

1640

The Chair: I think we should defer consideration of those until members have had an opportunity to look at them, and given the hour, I would suggest that we wouldn't do that until tomorrow

Mrs Sullivan: That's fine with me.

The Chair: We'll stand it down. We'll continue on, but we'll just have to come back to those.

Ms Sullivan, you also had a further amendment. Do you wish to proceed with that?

Mrs Sullivan: Yes. I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.5:

"Information to home

"9.5.1 A placement coordinator who authorizes a person's admission to an approved charitable home for the aged shall, if the person consents, give to the approved corporation maintaining and operating the home any of the following information that the placement coordinator has.

- "1. Information about assessments of the person.
- "2. Information about the person's social and personal care needs.
- "3. The name and address of anyone who is authorized to make decisions for the person.
 - "4. Information about the person's medical history."

Basically this is to ensure that the information on which the placement coordinator has based the assessment of eligibility and providing the authority to admit does not rest for ever in the placement coordinator's drawer but must be moved on to the home at which the person will receive care.

The Chair: Any further comments, parliamentary

Mr Wessenger: I think we'd better stand this one down because I think legislative counsel—no, not legislative counsel but counsel—has indicated some need to take a look at it

The Chair: So you wish to stand that down?

Mr Wessenger: Yes.

The Chair: The next one then is a government motion.

Mr Wessenger: I move that section 9.6 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by:

- (i) striking out "a placement coordinator or a member" in the second and third lines and substituting "an"; and
 - (ii) adding the following subsection:

"Placement coordinator's liability

"(2) Subsection (1) does not relieve a placement coordinator of liability for the acts or omissions of its employees or agents."

Mrs O'Neill: I had trouble with this as I read it and as you read it, "a placement coordinator," because there seems to be this nebulous, is it a person; is it an agency? We can't get it pinned down, and here particularly, where there's a liability, if there's an agency looking after this activity in a community, is there one placement coordinator with assistance? Many of these things now are done by boards. This is very confusing for the general public, and certainly for us. Can you say "a placement coordinator or agency"?

Mr Wessenger: I will ask Mr Quirt to clarify that for us.

Mr Quirt: The wording is that way so it can cover off a number of different placement coordinators that will be necessary in a sequence. To be very specific, it would be the intention to designate the existing placement coordination services, as the placement coordinator under the bill, those agencies that may deliver other services or may be standalone agencies with the single function of doing placement coordination.

But, as you know, about half the province currently is not covered by the placement coordination service program, so interim arrangements would have to be made designating, for example, a facility administrator who would make those determinations now, as the placement coordinator, until a placement coordination service can be established. It would be a priority for the government to get them up and running as soon as possible in the balance of the province.

As we've also pointed out, the function of placement coordinator over time, and the human and financial resources associated with the independent placement coordination programs now, would become an important, key component of the multiservice agency. Eventually the multiservice agency would be designated under the bill as the placement coordinator. It is worded this way to allow us, first of all, to deal with the fact that half the province isn't covered currently, that new agencies would be designed.

nated as placement coordination services and that eventually multiservice agencies would assume that function.

Mrs O'Neill: So a placement coordinator is really a position.

Mr Quirt: The placement coordinator may be an agency. You would be aware of the criticism of the bill that provided protection from liability for placement coordinators. This amendment is designed to still provide protection from liability for individual workers, but not the agency that employs those workers.

Mrs O'Neill: I'm sorry to continue but this is a very important piece. A placement coordinator, as defined here, is then an individual holding a position entitled "placement coordinator." Is that correct?

Mr Quirt: It would vary. In the cases where an individual agency like the VON was the placement coordination agency, we would designate the VON as the placement coordinator. In parts of the province where no placement coordination agency exists—

Mrs O'Neill: But then the VON would be liable.

Mr Quirt: —it would be perhaps an administrator of a facility who would be designated.

Mrs O'Neill: You just said the VON wouldn't be liable or an agency wouldn't be liable, but the individual—

Mr Quirt: No, the other way around. The individuals are protected from liability. But in the case where the VON was the placement coordinator, the board of the VON would be liable for the actions of those placement coordinators and would be required to have the appropriate insurance coverage in the service agreement that we'd have with them for that placement coordination service.

Mrs O'Neill: I think I've got it now. Oh, wow.

Mr Wessenger: I don't know whether I should ask legal counsel to clarify, but basically the liability is placed on placement coordinators. If the placement coordinator is an agency, then the agency would be liable. If the placement coordinator is an individual name, they would also be liable. The employees of an agency or the employees of the individual designated for that would not have the liability. But the only individuals who are likely to be named are those in the interim with respect to facilities.

Mr Wiseman: Can you repeat that last part?

Mr Jim Wilson: Yes, he was ahead before he spoke. No, it was a good explanation, really, by Mr Wessenger. I just wanted to add our support to this amendment. I think it responds to the concern that witnesses had about the blanket immunity placement coordinators were enjoying in the original draft of the legislation. I think the government has been responsive to that concern that was expressed, and we will be supporting the amendment.

The Chair: Thank you. Then if I can put the motion moved by Mr Wessenger, all those in favour? Opposed? Carried.

The next amendment-

Mrs O'Neill: I'm sorry, Mr Chairman, but there is no definition of "placement coordinator" anywhere in this bill. Correct? I mean, the people who are going to interpret

this bill are not going to have Mr Wessenger beside them to say what he just did, or Mr Ouirt.

Mr Jim Wilson: You don't know what he's going to do after politics.

Mrs O'Neill: May I just find out, is there a definition of "placement coordinator" in this bill?

The Chair: The parliamentary assistant.

Mr Wessenger: I'll ask legal counsel to reply to that.

Ms Czukar: No, there's no definition. Placement coordinators are those designated by the minister, so there is no definition in the bill.

The Chair: The next amendment is a Liberal amendment. Ms Sullivan.

Mrs Sullivan: As a result of the amendments made by the government with respect to the determination of eligibility and authorization for entry and enabling the home to serve notice that it is unable to care for a person, this motion is now redundant and I will not put it forward.

The Chair: Thank you. Mr Wilson, this is now section 9.6.1, am I right, two pages? Mr Wilson, section 9.7.

Mr Wessenger: Could our motion be first, section 9.7?

The Chair: It would be the government motion first, would it not?

Mr Wessenger: We have very similar motions.

The Chair: Mr Wessenger, why don't you put your motion.

Mr Wessenger: I move that section 9.7 of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Notice of determination

"9.7(1) If a placement coordinator determines that an applicant for a determination respecting eligibility for admission to an approved charitable home for the aged is not eligible, the placement coordinator shall ensure that the applicant and the person, if any, who applied for the determination on behalf of the applicant are notified of,

"(a) the determination of ineligibility;

"(b) the reasons for the determination; and

"(c) the applicant's right to apply to the appeal board for a review of the determination.

"Application to appeal board

"(2) The applicant may apply to the appeal board for a review of the determination of ineligibility made by the placement coordinator."

This change provides that an applicant for eligibility for a facility admission and any person who may have applied for admission on the applicant's behalf are to be notified if the applicant is found to be ineligible.

Provisions with respect to service of notice, extension of time and notice to the minister by the placement coordinator have been deleted. This amendment also eliminates the requirement that the applicant must request a review within 30 days. This really makes the whole process less formal. It was brought to us on many occasions during the hearings that they wanted to see a less formal process. Also, I think it's been simplified to give the placement

coordinators more flexibility when notifying someone of the decision regarding ineligibility.

Mrs Sullivan: I have an amendment I'm going to speak to while I speak to this one. It immediately follows.

The Chair: Just so we're clear, that is your subsection 9.7(1)?

Mrs Sullivan: Yes, and then subsections (2.1), (3), (4), (5) and (7).

The Chair: Just for committee members, it's the next proposed Liberal amendment which is two pages. Correct?

Mrs Sullivan: Right.

There are two issues I want to discuss with respect to this amendment. I understand the government's intent to simplify the process and I think that's laudable; however, there is no necessity for a person to receive any notification from a placement coordinator if he is eligible for admission to a home.

All of the notification processes apply with respect to a person who has applied and is found ineligible and therefore has the right to appeal, but there is no requirement that the placement coordinator should notify somebody who has been found to be eligible for placement and therefore eligible to be authorized for admission.

The amendment I am placing, which follows, would ensure that the placement coordinator would provide notice of determination, whether it's of eligibility or ineligibility, the entitlement to a hearing, the priority level and the requirements for obtaining an extension of time if they want to appeal the hearing.

I think there could be a combination motion here, but I really feel it's incumbent on the placement coordinator and should be legislated that the placement coordinator should inform a person if he is eligible, so the person will know what the next steps will be, or if he is ineligible.

The Chair: Mr Wilson, did you have—Interjection.

The Chair: If I might, just while you're reflecting on your comments, we will deal with this proposed amendment and then we will have to adjourn for today. We have suggested that we would reconvene tomorrow morning at 9:30. I'm prepared to consider 9 o'clock. I think we may wish to go until 12:30 and just have an hour for lunch, but perhaps I can just leave that with you while we then consider this.

Mr Jim Wilson: Mr Chairman, just following on Mrs Sullivan's comments, I would think that a placement coordinator would be eager to tell someone that he or she is eligible. While I agree with what the Liberal motion is trying to do, I don't support it in that I don't think it's terribly necessary. That brings me to the toss-up between the government motion and the PC motion.

I note the government motion dealing with this section is very similar to the motion I was considering putting forward, although my motion talks about also informing the consumer of the priority rating, even though that person may be deemed ineligible for admission.

Because I think we can't totally ignore some of the contents of the Liberal motions, my preference at this late

hour, Mr Chair, would be to actually deal with this whole conundrum tomorrow, because I can see a couple of problems that may need further debate.

The Chair: You're referring here to some combination of what the government has proposed and what you and the Liberal amendment—there may be some mélange there that would be acceptable if—

Mr Jim Wilson: I'd like to hear what Mrs Sullivan has to say about that. Before I do that, I am willing, if you want to deal with this right now, to say that I'm supportive of the government's amendment. I think it clarifies the placement coordinator's role regarding eligibility determination, and I think the government has come some way in benefiting consumers. In order to make the system more accountable, consumers must be notified of their standing, once determination is made by the placement coordinator, and of course that's the intent of these motions.

The Chair: Would it be agreeable to deal with the government motion at this point, and then are you suggesting that we would begin in the morning with your proposed amendment and the Liberal amendment?

Mr Jim Wilson: Perhaps Mrs Sullivan can best answer that, because I think the Liberal amendment goes a lot farther than either mine or the government amendment.

Mrs Sullivan: Interestingly enough, I think we're all very close here. Both the third party and the Liberal amendment would strike out the words "determination of ineligibility" throughout that section, which follows directly on the Liberal amendment in 9.7(1), where the "determination of ineligibility" becomes a "notice of determination," so the intent there is very similar.

The contents of the notice under the third party amendments with respect to priority level, the government probably doesn't want included, and the requirements for obtaining an extension of the time, I'm prepared to take out of my amendment, but there's a lot in all of these amendments that is very similar and I think we can work out a compromise.

The Chair: Can I put the motion then? Mr Wessenger's motion: all those in favour? Opposed? Carried.

Mrs Sullivan: That having been done, then we can't do ours.

The Chair: That being carried, do I take it then, just to be clear, Mr Wilson, that your proposed amendment is withdrawn?

Mr Jim Wilson: It hasn't been read in. I don't think there's any need to introduce it if we're going to go with the government amendment.

The Chair: Mrs Sullivan, when we return tomorrow morning, we would begin—yours has been superseded by what we have just approved.

Mrs Sullivan: That's right, basically.

The Chair: Could I then ask for the committee's help here? I think we have made excellent progress. I think members can understand that because many of the amendments we're dealing with in this section are triplicated, having worked our way through this, it will vastly simplify our task in the other two. Even though it looks like there's

a lot still to go through, and while in a sense there is, we have dealt with many of the major points. But we still have some to do.

I need some direction here just to ensure that we complete our work carefully tomorrow. We can begin, I think, at 9:30 or at 9, and I would further propose that we just take an hour at lunch. Any thoughts: 9:30 or 9?

Interjections: Nine-thirty.

The Chair: Okay, 9:30, and we would go to 12:30 and then reconvene at 1:30? All right. With that, then, we will adjourn until 9:30 tomorrow morning.

The committee adjourned at 1701.





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Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer

Jamison, Norm (Norfolk ND) for Mr Drainville

Mammoliti, George (Yorkview ND) for Mr Owens

O'Connor, Larry (Durham-York ND) for Mr Gary Wilson

Sullivan, Barbara (Halton Centre L) for Mr Daigeler

Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Wiseman, Jim (Durham West/-Ouest ND) for Mr White

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel:

Gottheil, Joanne, legislative counsel Spakowski, Mark, legislative counsel

^{*}In attendance / présents





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Wednesday 24 March 1993

Journal des débats (Hansard)

Mercredi 24 mars 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993



Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée

Chair: Charles Beer Clerk: Douglas Arnott Président : Charles Beer Greffier : Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 24 March 1993

The committee met at 0934 in room 151.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993

LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. Welcome again to the meeting of the standing committee on social development. We are doing clause-by-clause on Bill 101, An Act to amend certain Acts concerning Long Term Care, and we'll begin this morning with Ms Sullivan and an amendment to section 5 of the bill.

Mrs Barbara Sullivan (Halton Centre): My motion is with respect to section 9.7.1 of the act.

I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.7:

"Notice of determination to person seeking admission

"9.7.1(1) A placement coordinator who determines that a person's admission to an approved charitable home for the aged should not be authorized shall serve a notice of the determination on the person.

"Applicable provisions

"(2) Subsections 9.7(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (1).

"Hearing by appeal board

"(3) A person who is served with a notice of determination is entitled to a hearing by the appeal board if the person mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(4) Subsections 9.8(1), (2), (3) and (5) apply, with necessary modifications, with respect to a hearing requested by a person under subsection (3).

"Powers of appeal board

"(5) After a hearing by the appeal board, the appeal board may,

"(a) affirm the determination made by the placement coordinator:

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the person's admission to the approved charitable home for the aged."

The intent of this motion is to allow an applicant the right of appeal on the placement coordinator's determination that the person should be authorized to be admitted to a home. It is an add-on to the entitlement to appeal on eligibility.

Mr Paul Wessenger (Simcoe Centre): This is with respect to appeal, if I understand this. I have some difficulty understanding this motion because it appears to indicate—the role, it seems, of a placement coordinator in the act is to determine eligibility, not to determine that a person—that is covered in the previous section, as far as I can see, 9.7, which indicates a right of appeal when there's a determination respecting eligibility. For that reason, I don't see the purpose of this, and we'll be voting against it.

The Chair: Thank you. Shall the motion by Ms Sullivan carry? All in favour? Opposed? The motion is defeated.

Mr Jim Wilson (Simcoe West): I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.7.

"Discharge for transfer

"9.7.1(1) An approved corporation maintaining and operating an approved charitable home for the aged may apply, in accordance with the regulations, to the placement coordinator designated for the home for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the home.

"Determination

"(2) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the home.

"Authorization

"(3) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the applicant on an appropriate alternative setting for the resident.

"Discharge

"(4) An applicant may discharge a resident of an approved charitable home for the aged when so authorized by a placement coordinator.

"Notice of determination

"(5) The placement coordinator shall serve notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the home and determines not to authorize the resident's discharge, and subsections 9.7(2) to (7) apply with necessary modifications."

With this amendment, the duties of the placement coordinator will be expanded in order to ensure that an applicant's authorization of admission does not become the final task of the placement coordinator. Repeatedly,

this committee has been told that the condition and needs of the elderly, for instance, can change radically and rapidly. Bill 101 fails to address the issue of what happens to a resident once the current home is no longer capable of meeting his or her needs. Instead of closing the file on an applicant once he or she has been placed in a facility, the placement coordinator should be required to follow through when the situation deems it necessary to re-examine his or her placement in the home. This role, which cannot simply be ignored by the government, in my opinion, must be filled.

I propose that placement coordinators be required to fill this role. They are the natural choice since they will already be charged with the duty of determining eligibility and authorizing admission into a facility, and it follows that they should be the ones to seek out alternatives when arrangements are no longer suitable.

Mr Wessenger: We'll be voting against this motion because it is contrary to the scheme of the existing situation, where basically the onus is to find the alternative and then to get the—the way the process is to work is that where there is an inappropriate setting, an application will be made to an appropriate setting and then, once that appropriate setting is available, the applicant moved. We don't want to have persons left in limbo with a discharge provision.

Mr Jim Wilson: Just to be clear, perhaps the parliamentary assistant would want to place on the record what the process will be then if the resident of a home finds that the home no longer meets his or her needs and requirements. It would be my understanding that without this amendment, the process would be that the administrator of the home or someone at the home or the resident himself would apply for a transfer, apply back to the placement coordinator. Would that be the case?

Mr Wessenger: I will ask ministry staff, actually, because I think this is an area where they can provide more detailed answers.

Mr Geoffrey Quirt: Thank you. Geoff Quirt, acting executive director of the long-term care division.

If it's determined in developing the care plan or reviewing the care plan for a resident in a long-term care facility, with the involvement of the multidisciplinary team in the facility and with the required involvement of the resident himself or herself or his or her family members, that the appropriate type of service required by the resident can no longer be provided in the facility, then an application could be made, and would be made, with the applicant's consent, or the family's consent, to another long-term care facility in the area, for example, one with a secure unit if someone's behaviour, as the result of a cognitive impairment, indicated that this would be a better placement. Then the placement coordinator would be obliged to determine the priority of that person's application for the facility of his or her choice and make sure she or he had a fair shot at getting into that alternative facility.

If care in a hospital setting, for example, was indicated, then a placement coordinator could be called upon to make a referral, or the physician involved in the care planning of the individual could make a referral through a chronic hospital, and if a bed were available, the physician could admit the client to a chronic hospital or make a referral to another institutional setting specific to that client's needs.

We feel the placement coordination service will play a role in the way you've described, but we don't see the placement coordinator involved in declaring someone no longer appropriate for that facility. We would rather see a collaborative approach to determining the care requirements of the individual, without the threat of being declared no longer appropriate and with the insecurity of not having a future in that particular facility or another one that would meet their needs.

The Chair: Thank you. Shall the motion moved by Mr Wilson carry? All those in favour? Opposed? It is defeated.

The next motion is Mrs Sullivan.

Mrs Sullivan: I believe this motion responds to the exact comments of the parliamentary secretary.

I move that section 5 of the bill be amended by adding the following sections to the Charitable Institutions Act, after section 9.7.1:

"Discharge for transfer

"9.7.2(1) An approved corporation maintaining and operating an approved charitable home for the aged may apply, in accordance with the regulations, to the placement coordinator designated for the home for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the home.

"Notice to resident

"(2) The applicant shall give notice of the application to the resident.

"Determination

"(3) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the home.

"Authorization

"(4) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the resident on an appropriate alternative setting for the resident.

"Discharge

"(5) An applicant may discharge a resident of an approved charitable home for the aged when so authorized by a placement coordinator if an appropriate alternative setting for the resident is available and transfer to that setting is consented to by the resident or person authorized to consent on behalf of the resident.

"Notice of determination

"(6) The placement coordinator shall serve a notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the home and determines not to authorize the resident's discharge.

"Applicable provisions

"(7) Subsections 9.7(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (6).

"Hearing by appeal board (discharge)

"9.7.3(1) An approved corporation that is served with a notice of determination under subsection 9.7.2(6) is entitled to a hearing by the appeal board if the approved corporation mails or delivers to the placement coordinator and to the appeal board, within 30 days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(2) Subsections 9.8(1), (2), (3) and (5) apply, with necessary modifications, with respect to a hearing required by an approved corporation under subsection (1).

"Powers of appeal board

"(3) After a hearing by the appeal board, the appeal board may,

"(a) affirm the determination made by the placement coordinator:

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the resident's discharge."

Mr Chairman, as is very clear, there is concern about what will happen to a resident when the care requirements can no longer be met at the facility and the facility believes that to be the case.

This motion is similar to the motion of the third party; however, improves upon it, in my view, in several areas. First of all, the resident is notified that the nursing home or the home for the aged would be making an application for transfer. Secondly, the transfer could only occur if an alternative setting is available and ready to accept and able to accept the person, and there is a hearing allowed before the appeal board of the application if the placement coordinator says that a transfer is not appropriate.

The Chair: Parliamentary assistant.

Mr Wessenger: We'll not be supporting this amendment because again, if I might refer, it introduces the concept of the appeal process, which we want to deal with in phase 2.

The Chair: Shall the motion moved by Ms Sullivan carry? All in favour? Opposed? The motion is defeated.

The next amendment is a government motion on subsections 9.8(1) and (2).

Mr Wessenger: I move that subsections 9.8(1) and (2) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Hearing

"9.8(1) When the appeal board receives an application for a review of a determination of ineligibility, it shall promptly appoint a time and place for a hearing.

"Same

"(2) The hearing shall begin within twenty-one days after the day the appeal board receives the application for the hearing, unless the parties agree to a postponement.

"Notice to parties

"(2.1) The appeal board shall notify each of the parties of the time and place of the hearing at least seven days before the hearing begins.

"Parties

"(2.2) The parties to the proceeding before the appeal board are the applicant who was determined to be ineligible for admission, the placement coordinator who made the determination and such other parties as the appeal board specifies.

"Notice to minister

"(2.3) When a placement coordinator is notified by the appeal board of a hearing, the placement coordinator shall promptly give the minister written notice of the hearing together with written reasons for the determination of ineligibility made by the placement coordinator.

"Minister entitled to be heard

"(2.4) The minister is entitled to be heard by counsel or otherwise in a proceeding before the appeal board under this section."

This amendment again simplifies the hearing parties and notice provisions and also requires the appeal board to notify parties at least seven days before the hearing and requires the hearing to begin within 21 days. Again, it's to simplify the process and to expedite it.

Mrs Sullivan: What is the difference between the yellow page and the white page?

Mr Wessenger: I'll ask counsel.

Ms Gail Czukar: It's a drafting issue. I think legislative counsel might be able to explain what the difference was between our original tabled motion and this one. It's a small drafting change of some sort.

Ms Joanne Gottheil: In section 9.8(2) the words "unless the parties agree to a postponement" were added to give the parties that right. In subsection (2.1) it had said "before the hearing," and we just said "before the hearing begins." Those were the only changes.

The Chair: Shall the government motion carry? All in favour? Carried.

The next motion is a Conservative motion. Mr Wilson.

Mr Jim Wilson: I won't be introducing this motion as the government motion incorporates in it a time frame for the hearing of the appeal. I see some strange looks from counsel. Was I correct in my comments on that?

Mr Wessenger: Yes, you were correct.

Mr Jim Wilson: I was proposing 90 days and you proposed 21, and I think 21 is preferable.

The Chair: We'll simply learn from that. Strange looks do not necessarily mean—

Interjections.

The Chair: Order. We'll move to the government motion on subsection 9.8(3).

Mr Wessenger: I move that subsection 9.8(3) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Ouorum of appeal board

"(3) Three members of the appeal board constitute a quorum and are sufficient for the exercise of the jurisdiction and powers of the appeal board under this act."

This of course changes the quorum from one to three, as requested by many presenters.

The Chair: Any comments?

Mr Jim Wilson: Just to indicate that we'll be supporting this government amendment. I know many witnesses appeared before the committee feeling that a quorum of one was insufficient. Arguments have also been made that perhaps a quorum of three may slow down the process of the appeal board. I'd just like to take this opportunity to ask the parliamentary assistant what the government envisions in terms of beefing up the staffing levels and resources of the appeal board so that we not only get rid of the backlog that faces the board now but it's also able to take on the new challenges presented to it through this legislation.

Mr Wessenger: I'd be happy to respond to that. In fairness, I think this is an aspect by which we are looking to respond to the presenters, but I would agree that it's a very mixed situation, because by establishing a quorum of three you may not make the process as simple as it might otherwise be with a hearing by one person. I'll be quite honest about this item, that I'd be quite prepared to let everybody look at it individually and make their own decision on this particular item. If it's the consensus of the committee that—

Interiections.

Mrs Sullivan: Free vote.

Mr Jim Wilson: He's telling his own members, "You can do whatever you want on this."

Mr Wessenger: No. I'm just—

Mr Jim Wilson: Given, Mr Wessenger, that this is the first time you've released the whip on your members, is there something here we should know about?

Mr Wessenger: I think it's fair to say it's a balance question. It's a difficult—

Mr Jim Wilson: Let me just ask you, is it the government's opinion that this will be problematic if you move to a quorum of three? Have you figured out whether you're going to have the resources throughout the province to be able to do this, or are we doing this for political reasons because a lot of groups indicated they wanted a quorum of three?

Mr Wessenger: I think it's fair to say that a quorum of three is preferable from an administrative point of view, in the sense of providing a hearing that will be less likely to be attacked and provide a more final decision. So certainly it is in my opinion preferable from that aspect. It's a question of balancing that interest, which I tend to favour, against the other interest of having a more informal, quicker process perhaps.

Mrs Yvonne O'Neill (Ottawa-Rideau): I have considerations on this matter too. I'm comparing it to the Social Assistance Review Board, where there is a quorum of one, and we haven't had a lot of pressure to change that.

It's an area, too, where there is a lot of demand for hearings. This could delay things considerably for individuals who are in a vulnerable position.

It also is going to really increase the costs in a province like Ontario to have a quorum of three. It may not always be that three people are in the same city in this province. I think it is a political move. I think that if the regulations are very clear, if the criteria from ministry are very precise regarding decisions and precedents, and decisions are set up—and there are already some precedents in this area in this province—I think a quorum of one is quite defensible.

The Chair: I think the arguments have been made and

Mr Wessenger: It's a free vote.

Interjections.

The Chair: Order. Ladies and gentlemen of the committee, as the Chair, I must remind you that we have a good number of amendments to deal with today. While I appreciate the bonhomie that reigns, we really must push on.

Shall the motion put by the parliamentary assistant carry? All those in favour? Seven. All those opposed? Three. So the motion carries.

The next motion is a Liberal motion.

Mrs Sullivan: There's a government motion before my own, which is exactly the same as my own.

The Chair: I'm sorry, I'm working from two lists. You're quite right: A government motion is first.

Mr Wessenger: I move that subsection 9.8(4) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out.

The Chair: Shall the motion carry? Carried. I believe I am finally at Ms Sullivan.

Mrs Sullivan: Mr Chairman, my motion was exactly the same as the government's, so I will not be putting it forward.

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The Chair: Okay. Mr Wilson, I believe yours is-

Mr Jim Wilson: My motion is exactly the same, too. May I just add the comment that the reasons, I believe, for all three parties having the same motion is that we felt it was unnecessary and discriminatory to limit the number of physicians who can sit on the appeal board. For this reason, I think the parties agreed to support the government motion.

The Chair: Thank you. Next is a government motion. Mr Wessenger.

Mr Wessenger: I move that section 9.8 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsections after subsection (5):

"Evidence of disabled person

"(5.1) If a party to a proceeding before the appeal board under this act wishes to give evidence in the proceeding or wishes to call another person as a witness to give evidence in the proceeding but the party or other person is unable to attend the hearing by reason of age, infirmity or physical disability, the appeal board members holding the hearing may, at the request of the party, attend upon the party or

the other person, as the case may be, and take his or her evidence.

"Medical report proves inability

"(5.2) A medical report signed by a legally qualified medical practitioner stating that the practitioner believes that the person is unable to attend the hearing by reason of age, infirmity or physical disability is proof, in the absence of evidence to the contrary, of the inability of the person to attend the hearing.

"Opportunity for all parties

"(5.3) No appeal board member shall take evidence from a party or other person under subsection (5.1) unless reasonable notice of the time and place for taking the evidence is given to all parties to the proceeding and each party attending is given an opportunity to examine or cross-examine the party or other person, as the case may be.

"Recording of evidence

"(5.4) The oral evidence taken before the appeal board at a hearing and the oral evidence taken from a party or other person under subsection (5.1) shall be recorded and, if required, copies of a transcript of the evidence shall be furnished on the same terms as in the Ontario Court (General Division)."

This amendment permits elderly, infirm or physically disabled persons or witnesses to give evidence without having to attend the hearing. As well, it provides that oral evidence is to be recorded. This is really to provide a fairer hearing process, particularly for the infirm.

The Chair: Thank you. Shall the motion made by Mr Wessenger carry? Carried.

Mr Wessenger, yours is next.

Mr Wessenger: I move that subsection 9.8(6) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Health Insurance Act

"(6) Subsections 23(1), (2), (4), (5) and (6) of the Health Insurance Act apply to the proceedings and decisions of the appeal board under this act."

This amendment deals with appeal board procedure described under the Health Insurance Act. It deletes a reference to subsection 23(3) of that act regarding copying of transcripts and recording of evidence, which is not necessary because the previous motion we just passed ensures that transcripts are copied and the evidence recorded.

The Chair: Shall the motion by Mr Wessenger carry? Carried.

Mrs Sullivan, I'm not sure if yours is-

Mrs Sullivan: This motion is the same as the motion preceding it.

The Chair: Thank you. Mr Wilson, yours is next, 9.8(7).

Mr Jim Wilson: This was a housekeeping item which would have referred to a previous PC amendment to introduce an appeal opportunity and, as I said yesterday, given that you never got this house set up, I won't be introducing this housekeeping item.

The Chair: Thank you. The next is a government motion, Mr Wessenger.

Mr Wessenger: I move that section 9.8 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection after subsection (7):

"Decision and reasons

"(7.1) The appeal board shall render its decision within one day after the end of the hearing and shall provide written reasons to the parties within seven days after rendering the decision."

Again, this is to ensure we have a speedy process.

Mrs Sullivan: I have some concern here that indeed this will be possible and reasonable, making a decision within a day, if the case is complicated, if the eligibility materials that have to be reviewed, by example, include substantial medical evidence and so on. I think the ministry may be overconfident in putting this forward. I like the idea of speed; I'm just not sure if this is the right speed.

Mr Jim Wilson: I just want to note that there is some inconsistency here on behalf of the government in that both the PC Party and the Liberal Party introduced many amendments to try to expand the appeal provisions in this particular section of the legislation, including the PC amendment which did refer to a similar time guideline as is now contained in the government's own motion. For that reason, I guess I have to support the government motion, but I do want to put on the record that we're still very disappointed that expanded appeal opportunities don't exist in this section.

Mrs O'Neill: I'm quite concerned about the possibility of this. We all know that it's not always possible to gather evidence and to contact people, even by telephone. These decisions, let's face it, are going to be the difficult decisions. I really don't think that in 24 hours it is possible to make any difficult decision in government. I think it's putting out a false hope that it will not be possible to meet. Putting it into legislation, in my mind, is almost ridiculous.

Mr Wessenger: I'd just like to indicate that presently under the Mental Health Act and under the new Consent to Treatment Act, which involve serious questions of mental capacity, the requirement is that the review board make a decision within one day. So I think that if we look at the similarity of cases, those cases are, if anything, more complex than the question of determining a person's level of care.

The Chair: I'll put the question, then. Shall the motion by Mr Wessenger carry? All in favour? Carried.

Next is a Conservative motion. I'm sounding quizzical because I'm trying to find it.

Mr Jim Wilson: It's subsection 9.8(6) for the Liberals.

The Chair: I'll just pause for a second here.

Mr Randy R. Hope (Chatham-Kent): I've got the Conservatives' section 9.8.1.

The Chair: You have a motion to section 9.8.1, Mr Wilson?

Mr Hope: Powers of court on appeal.

Mr Jim Wilson: Again, I won't be introducing that amendment on section 9.8.1. It's a housekeeping item

which referred to a previous amendment which would have expanded the appeal process.

The Chair: Okay. I then have a Conservative amendment to section 9.10.

Mr Jim Wilson: I'm sorry, which amendment are you looking for?

The Chair: Subsections 9.10(3) to (5).

Mr Jim Wilson: I'm confused, because I have an amendment here in my pile that I guess never made it to the pile that everybody else is looking at.

The Chair: I've had a little confusion here too. Do you want to share your confusion with my confusion?

Mr Jim Wilson: Again, just to be clear, I will not be introducing the PC amendment to subsections 9.10(3) to (5).

The Chair: Okay, thank you. I then have a government amendment to section 9.12.

Mr Wessenger: I move that section 9.12 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by striking out "and" at the end of clause (c) and by adding the following clause after clause (c):

"(c.1) an opportunity to participate fully in the development and revision of the resident's plan of care is provided to the resident, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct; and"

This amendment requires a home to provide residents and their substitute decision-makers with an opportunity to participate in the plan of care. It was always the intention that this be the case anyway, but this is in response to the recommendations made by the consumers. But I ask that this be stood down until the substitute decision-making amendment is accepted, because there are some provisions in that section.

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The Chair: Okay, so 9.12 will be stood down.

We move then to the next amendment, 9.12(d), which is a Liberal amendment.

Mrs Sullivan: I move that clause 9.12(d) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out.

This motion and the one which I will be making subsequent to it—I can do the argumentation for both at once—are really to indicate that the standard of demand that is being required of the home with respect to the provision of the plan of care in 9.12(d) is an impossible one in that the plan of care will not be totally provided by the home, yet the home is being required to provide, under this section, the entire plan of care. It's an impossible one. The standard is much too high.

My next motion would strike out that—actually, probably what I should do is go on to the next motion.

The Chair: I just want to ask: You're really making changes—

Mrs Sullivan: Yes, I'm doing double duty here, aren't I?

The Chair: Would it make more sense to just remove this one?

Mrs Sullivan: Yes. I'll withdraw that, then, and

I move that clause 9.12(d) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"(d) those parts of the plan of care for which the approved corporation is responsible under the service agreement or a contract between the approved corporation and the resident is provided to the resident."

The Chair: I see some quizzical faces—

Mrs Sullivan: Yes, I know.

The Chair: —which suggests people may not have that.

Mr Jim Wilson: I think she's added a few words on the fly.

Mrs Sullivan: No, look at the next page.

The Chair: There should have been two pages, but if you don't have that, let's make sure we get that one. Ms Sullivan, could we come back to that once we've distributed that?

Mr Jim Wilson: Mr Chairman, we do have a couple of pages of Liberal motions. One looks like version 2.

Mrs Sullivan: We had difficulty in the wording here.

Mr Jim Wilson: Maybe Ms Sullivan could just repeat the wording.

The Chair: Ms Sullivan, there were three related to 9.12(d): the one that simply struck it out, and then there are two pages we have that amend it. Which one do you—

Mrs Sullivan: It would be the second page:

"(d) the care outlined in the plan of care, for which the approved corporation is responsible for providing under the service agreement or a contract between the approved corporation and the resident and for which the approved corporation has been compensated, is provided to the resident."

The Chair: Okay, that's the one you're presenting. The other one should be removed.

Mrs Sullivan: That's right.

The Chair: Is that clear to everyone? Any discussion on Mrs Sullivan's amendment?

Mr Jim Wilson: Mr Chairman, I realize this amendment stems from discussions opposition parties had with the Ontario Nursing Home Association, and I think that we can support Mrs Sullivan's version 2 or 3 of this amendment. I like it better than her previous thoughts, which would have removed the requirement for the home to ensure that the resident is provided with the plan of care.

I think it's important that residents know their plan of care and that somebody have the actual legislated responsibility to make sure they're aware of all of that. I know the government's moved to ensure that residents are fully consulted during the making of the plan of care and I do agree with this motion, which calls upon the government to provide, I believe, compensation to the homes to ensure that they're able to carry out what's required in the amendment.

Mr Wessenger: We'll be voting against this motion, because it would relieve the home from meeting requirements. It should be indicated, however, that the plan of care is developed by the homes, so they're the ones that are setting the plan of care.

The Chair: Shall the motion by Ms Sullivan carry? All those in favour? Opposed? The motion is defeated.

Ms Sullivan, yours is the next one as well, 9.12(2). In fact the next three are yours.

Mrs Sullivan: I move that section 9.12 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsections:

"Resident's participation in developing plan

"(2) A plan of care for a resident shall not be developed or revised without the participation of the resident or another person authorized to act on the resident's behalf.

"Resident's consent in implementing plan

"(3) A plan of care for a resident shall not be implemented without the consent of the resident or another person authorized to consent on the resident's behalf."

The motion is straightforward and would require involvement in the development of the plan and consent to its implementation.

Mr Wessenger: I will be voting against this because it appears to be covered by the amendment that we have already moved, 9.12.

Mrs Sullivan: Yours is stood down as I recall.

Mr Wessenger: It is stood down, but it will be-

Mrs Sullivan: Should we stand down this one to be certain that the points are included?

The Chair: You'll have to stand it down, Mrs Sullivan. So this is also deferred. We'll then move on to the next amendment which is also yours.

Mrs Sullivan: I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act after section 9.12:

"Immunity for employees

"9.12.1 No proceeding for damages shall be commenced against an employee of an approved charitable home for the aged for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in good faith of the person's duty."

We felt this was an important amendment to include, given the immunity provisions, even with the changes surrounding the placement coordinator.

Mr Wessenger: We'll be voting against this motion for the simple reason it would, I think, open a Pandora's box with the whole question of all employees in health facilities, because in the Public Hospitals Act, employees are personally liable to provide a different situation within a long-term care facility. To my way of thinking, it does not make sense.

The Chair: Shall Ms Sullivan's motion carry?

Mr Cameron Jackson (Burlington South): Could we have a recorded vote on this?

The Chair: A recorded vote?

Mr.Jackson: Please.

The Chair: I'm going to call for a recorded vote and we will do so. Shall the motion made by Ms Sullivan carry? All those in favour?

Ayes

Jackson, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Navs

Hope, O'Connor, Owens, Wessenger, Wiseman.

The Chair: The motion is defeated.

I now call the government motion on 9.13.

Mr Wessenger: I move that section 9.13 of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Ouality management

"9.13 An approved corporation maintaining and operating an approved charitable home for the aged shall ensure that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the home."

This is in response to the many representations that "quality assurance" was inappropriate language.

Mr Jim Wilson: I just want to make a few comments on the amendment and about quality assurance versus quality management. I think Bill 101, without this amendment, simply required each home to develop quality assurance programs.

Quality assurance is a management approach. Studies have argued that quality assurance does not improve the quality of care for a patient in a hospital, the studies that refer to the hospital sector. Instead, some hospitals use a total quality management approach, which has been proven to improve patient care.

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As the parliamentary assistant has indicated, several groups have told this committee that a quality assurance approach is outdated and conflicts with other management processes used in hospitals and nursing homes, and certainly our caucus believes that the most generic wording should be used in the legislation in order that facilities are continually improving the quality of service they provide.

Having said that, I want specifically to ask the parliamentary assistant whether he feels it is necessary to restrict the term "quality management," because in his amendment, after the word "implemented" in the third line, they go on to restrict quality management by inserting "for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the home."

I just wondered if the government would accept a friendly amendment—and I'm just feeling out the government at this point, Mr Chairman—that after the word "implemented" we simply put, "implemented for the home," and not have the extra language, which I feel somewhat restricts the term "quality management," because I'm told

by experts in this field that when they see the term "quality management," they know what it means and that it's not necessary to put any additional restrictions or commentary on that term, as the government's amendment would do.

The Chair: Parliamentary assistant, would you comment on that?

Mr Wessenger: I would suggest that by adding in the words, we particularly direct the intention of the legislation towards the quality of what is delivered, and I think it's important that that be set out in the description. It also makes it, in my opinion, more generic.

The Chair: Shall the motion made by Mr Wessenger carry? All in favour? Opposed? Carried.

The next motion is a Liberal motion.

Mrs Sullivan: Mr Chairman, my motion is now redundant.

The Chair: Thank you. The next motion is a Conservative motion. Mr Wilson.

Mr Jim Wilson: It's the same and it would be redundant. I do want to emphasize, though, that I think the government's motion, although we had to support it because it's the only one that was going to be passed today, is not our first choice.

The Chair: The next motion is also your motion, Mr Wilson.

Mr Jim Wilson: Again, Mr Chairman, I won't be introducing that.

The Chair: Right, thank you. I believe it's the government motion that's next, to section 9.14. Mr Wessenger, please.

Mr Wessenger: I move that section 9.14 of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Notice to residents

"9.14(1) An approved corporation maintaining and operating an approved charitable home for the aged shall give to each resident of the home, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct, a written notice,

"(a) setting out the rights of the resident under subsection 3.1(2) and stating that the approved corporation is obliged to respect and promote those rights;

"(b) describing the accommodation, care, services, programs and goods that the approved corporation is required to provide or offer under this act and under the service agreement relating to the home;

"(c) stating that the resident, the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care or such other person as they may direct may request access to and an explanation of the resident's plan of care, and specifying the person to whom such a request must be made;

"(d) setting out the procedures for making complaints about the maintenance or operation of the home, the conduct of the staff of the home or the treatment or care received by the resident in the home; and

"(e) setting out such other matters as are prescribed by the regulations.

"Obligations re plan of care

"(2) If a request is made in accordance with clause (1)(c), the approved corporation shall ensure that access to and an explanation of the plan of care is provided to the person who made the request."

This amendment adds a requirement that the person who's lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care should receive notice of the terms set out in this section, in addition to the resident. As well, it adds the bill of rights to the list of items which the approved corporation must provide notice of.

This again should be stood down until the substitute decision-making amendment is accepted.

The Chair: This will be deferred. Mr Wilson?

Mr Jim Wilson: To save a little time, the PC motion 9.14(1)(a), which I believe would be the next motion, also should be stood down because it's an amendment to part (a) of that.

The Chair: Okay, so we are deferring 9.14 and 9.14(1)(a), but we'll just hold for one moment. As the clerk quite rightly points out, would you please read it and move it.

Mr Jim Wilson: I move that clause 9.14(1)(a) of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"(a) the rights and obligations of the resident and of the approved corporation."

Perhaps I may just comment, because I think while it's stood down, the parliamentary assistant may want to consider these comments and why I think part (1)(a) of the government's motion should take into account my amendment. I think what the PC amendment attempts to do, in the addition of this wording, is to ensure that the relationship between residents and operators is a more balanced one. Currently under the bill, I believe this relationship is one-sided. The service agreement and plan of care are intended to make the operator live up to his or her end of the agreement, while nothing is provided to ensure residents comply with their end of the deal.

I'd ask the parliamentary assistant to take this amendment under consideration. What it attempts to do is to state in the legislation that not only should the rights and obligations of the resident be fully respected but also those of the corporation.

The Chair: Thank you. That will also be stood down. I'm sure the parliamentary assistant will consider your remarks when it is stood back up. That's probably grammatically incorrect, but none the less.

Mr Jim Wilson: You're doing very well, Mr Chair.

The Chair: We now move to 9.15.

Mr Wessenger: I move that section 9.15 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by:

(i) renumbering clause (a) as clause (a.1) and adding the following clause:

"(a) a copy of section 3.1"; and

(ii) adding the following clause after clause (a.1):

"(a.2) a copy of the most recent inspection report relating to the home received by the approved corporation under subsection 10.1(15)."

This amendment requires that an approved corporation post the section of the act concerning the bill of rights as well, just as they will be required to post recent inspection reports.

Mr Jim Wilson: Committee members may want to refer to both the Liberal and PC motions in this regard. It's difficult to talk about the government motion without talking about our own. Essentially, what I'd like to see changed in this section, in dealing with the posting of all of the documents that the government, through this legislation, is requiring to be posted in the home—what the PC motion attempts to do is to say that, yes, it's important, the principle regarding the posting of information such as service agreements, financial statements and other documents is a good principle.

But I think it overlooks a very important fact, which is that these facilities are residents' homes. I think the government may have lost sight of this in its attempt to ensure that advocacy is easily provided and easily carried out on behalf of residents, that residents themselves can easily find information about their homes and that their loved ones and families can easily obtain information and documents about the homes. I just find it somewhat unnecessary and perhaps really not the best way to proceed by having all of this documentation posted as you walk in the front door of someone's home.

1030

The PC amendment, and I think the Liberal amendment, says it's important that this information be available and that there not be any barriers to obtaining this information and documentation, but that it would be better that a sign be posted in the front lobby, as it were, indicating that all this information is available during posted hours at the office or nursing station. That is the intent of my amendment.

I'd like the government to comment on that, because what the government amendment that we're speaking to right now does is to require that even more information be posted on the bulletin board, as it were. I wonder if they'd consider the fact that this is someone's home.

The Chair: Just before calling on the parliamentary assistant, Mrs Sullivan, do you wish to comment, because you also have a similar amendment?

Mrs Sullivan: Yes, I do. The amendment we have proposed would require that information is available in a prominent place. In my view, that ought not to be the nursing station or the manager's office, but ought to be a place where the residents have independent access.

None the less, I concur with the view of the Ontario Nursing Home Association and the representatives of charitable homes who that their places are going to begin to look like a cluttered kindergarten room, with things on walls everywhere and no appropriate place for people to review properly the documents to which we want them to have full access.

The posting issue is one issue. The second issue is that the documentation should be available in a central location, which the residents should have unimpeded access to.

Thirdly, I think the government's approach is to list every document in the legislation that ought to be posted. It seems to me there ought to be another method whereby other information which the ministry may from time to time want to make available should be included in the regs. The government amendment does not allow for that, whereas the amendment that the Liberal Party is putting forward does.

Mr Wessenger: I just want to comment. The existing provisions that are being amended do provide that other documents may be required to be posted by regulation. As far as the prominent place thing is concerned, I know it just says to post it in the home in our provisions. But I'm certain it will be dealt with by regulation as to ensuring it is posted in a prominent place.

With respect to the Conservative amendment, we certainly would be concerned that just posting a right to inspect would not be an effective way of people having access to information, particularly those people who would be with the frail elderly.

Mrs Sullivan: I wonder if the government would consider a redraft to change the word "post" and substitute that word with words that would ensure independent access by the resident to materials that were located in a "common area or prominent place," in the words that were recommended to us? "Post" has a legal meaning, I'm told by counsel, that means it must be on the wall.

Mr Jim Wilson: Just following on what the parliamentary assistant has said, I think operators of homes for the aged and nursing homes and charitable homes—because we all have similar amendments to those acts to be presented later—try to make their facilities look like homes. Even now there's a certain amount of posting that has to go on. I find when I visit homes in my riding, residents get overly anxious about some of the stuff that's posted.

For instance, I was in a home before Christmas where a couple of residents were very concerned about a posting of an infringement of a fire regulation. The legal wording in that document had me worried until somebody expert in the field explained to me what it all meant, and it simply meant that they didn't have the proper doorstop on a particular fire exit. The scuttlebutt throughout the home certainly was that this home was in major violation of the fire code, which wasn't the case, and I found there was just sort of unnecessary anxiety.

Not that people shouldn't be entitled to that. My amendment clearly says that yes, they are entitled to these documents, but I don't want the place looking like an institution and I don't want institutional and legalistic documents hanging up on the bulletin board when I think it may be more appropriate to have a sign that lists what is available, that all of the documentation required under regulations and in the legislation be listed on the sign and that, as my motion reads, "The approved corporation shall post a notice in the home informing residents how they can inspect the documents referred to."

While I used in my earlier comments the example of the nursing station or the management office. I simply used those as examples. I agree that perhaps a more neutral area should be established for the review of these documents by residents.

The Chair: Miss Sullivan? Sorry, it's now the parliamentary assistant.

Mr Wessenger: The only comment I'll make is that I think consumer protection is very much an important part of this legislation and I think posting is very much an important part of consumer protection, and it's not just for the residents, of course, because in many instances it's the families that will really be exercising the consumer protection on behalf of their resident family member.

The Chair: Shall the motion put by Mr Wessenger carry? All in favour? Opposed? Carried.

Mr Wilson?

Mrs Sullivan: I'm next.

Mr Jim Wilson: Well, that depends on how the Chair calls it.

The Chair: For some reason I have Mr Wilson, but I think both of yours deal with the same-

Mr Jim Wilson: Mr Chairman, I would like to put this on the record.

I move that section 9.15 of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Having documents available

"9.15(1) An approved corporation maintaining and operating an approved charitable home for the aged shall ensure that the following documents are available for inspection in the home:

"1. A copy of the service agreement relating to the

"2. A copy of each of the financial statements, reports and returns that the approved corporation has filed with the minister under this act.

"3. All other documents that the regulations require the approved corporation to have available for inspection in the home.

"Notice to residents

"(2) The approved corporation shall post a notice in the home informing residents how they can inspect the documents referred to in subsection (1).

My previous comments stand, Mr Chairman.

The Chair: Ms Sullivan.

Mrs Sullivan: I too would like to read my own motion into the record. I don't know how we deal with this.

Mr Jim Wilson: I think you have to vote on the PC motion because it's on the floor, Mr Chairman.

The Chair: Shall the motion made by Mr Wilson carry? All in favour? Opposed? Defeated.

Ms Sullivan.

Mrs Sullivan: I move that section 9.15 of the Charitable Institutions Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Availability of information

"9.15 An approved corporation maintaining and operating an approved charitable home for the aged shall ensure that the following documents are made available in a prominent place in the home:

"1. A copy of the service agreement relating to the home.

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"2. Copies of those financial statements, reports and returns filed with the minister that the regulations require to be made available.

"3. All other documents and information that the regulations require to be made available."

The Chair: Shall the motion made by Miss Sullivan carry? All in favour? Opposed? Defeated.

Mr Wessenger, yours is the next one.

Mr Wessenger: I move that section 9.15 of the Charitable Institutions Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"(2) In posting anything under subsection (1), the approved corporation shall not disclose the salary of an individual."

This is important; we have consistency.

The Chair: Shall the motion by Mr Wessenger carry? All in favour? Carried.

The next motion is also a government motion.

1040

Mr Wessenger: I move that section 5 of the bill be amended by adding the following sections to the Charitable Institutions Act, after section 9.15:

"Residents' council

"9.16(1) If a request for the establishment of a residents' council is made to the administrator of an approved charitable home for the aged by at least three persons, each of whom is a person mentioned in subsection (2),

"(a) the administrator shall promptly notify the director and the approved corporation maintaining and operating

the home of the request; and

"(b) the approved corporation shall assist the persons who made the request in establishing a residents' council for the home within 60 days of the request.

"Request for residents' council

"(2) For the purpose of subsection (1), the following persons may request the establishment of a residents' council for an approved charitable home for the aged:

"1. A resident of the home.

"2. A person who is lawfully authorized to make a decision on behalf of a resident of the home concerning the resident's personal care.

"Right to be a member

"(3) The following persons are entitled to be members of the residents' council of an approved charitable home for the aged:

"1. A resident of the home.

"2. A person who is lawfully authorized to make a decision on behalf of a resident of the home concerning the resident's personal care.

"3. A person selected by the resident or by the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care.

"Who may not be a member

"(4) No officer or director of an approved corporation maintaining and operating an approved charitable home for the aged may be a member of the residents' council of the home, unless he or she is also a person mentioned in paragraph 1 or 2 of subsection (3).

"Same

"(5) No administrator or member of the staff of an approved charitable home for the aged may be a member of the residents' council of the home.

"Appointment by minister

"(6) At the request of a residents' council, the minister may appoint no more than three persons to be members of the residents' council, and those persons shall serve as members at the pleasure of the residents' council.

"Same

"(7) Only a person who lives in the area in which the approved charitable home for the aged is located and who is not employed by and does not have a contractual relationship with the ministry of the minister may be appointed under subsection (6).

"Meeting

"9.17(1) Unless an approved charitable home for the aged has a residents' council, the approved corporation maintaining and operating the home shall, at least once in each year, convene a meeting of the residents of the home and the persons who are lawfully authorized to make a decision on behalf of a resident concerning the resident's personal care, to advise them of their right to establish a residents' council.

"Results of meeting

"(2) Within 30 days after the meeting, the approved corporation shall notify the director of the results of the meeting.

"Powers of residents' council

"9.18 It is the function of a residents' council of an approved charitable home for the aged, and the council has the power, to,

"(a) advise residents of the home respecting their rights and obligations under this act;

"(b) advise residents of the home respecting the rights and obligations of the approved corporation maintaining and operating the home, under this act and under the service agreement relating to the home;

"(c) meet regularly with representatives of the approved corporation maintaining and operating the home to,

"(i) review inspection reports relating to the home received by the approved corporation under subsection 10.1(15),

"(ii) review the allocation of money for accommodation, care, services, programs and goods provided in the home.

"(iii) review the financial statements relating to the home filed with the minister under the regulations, and

"(iv) review the operation of the home;

"(d) attempt to mediate and resolve a dispute between the approved corporation maintaining and operating the home and a resident of the home; and "(e) report to the minister any concerns and recommendations that in its opinion ought to be brought to the minister's attention.

"Residents' council assistant

"9.19(1) With the consent of a residents' council, the minister may appoint a residents' council assistant to assist the residents' council in carrying out its responsibilities.

"Duties

"(2) In carrying out his or her duties, a residents' council assistant shall take instructions from and report to the residents' council.

"Information and assistance

"9.20(1) An approved corporation maintaining and operating an approved charitable home for the aged shall cooperate with the residents' council and the residents' council assistant and shall provide them with such financial and other information and such assistance as is required by the regulations.

"Obstruction

"(2) No person shall refuse entry to an approved charitable home for the aged to a residents' council assistant or otherwise hinder, obstruct or interfere with a residents' council assistant carrying out his or her duties.

"Offence

"(3) Any person who contravenes subsection (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for each subsequent offence.

"Immunity

"9.21 No proceeding shall be commenced against a member of a residents' council or a residents' council assistant for any act done under section 9.18 unless the act is done maliciously or without reasonable grounds."

This amendment adds a provision to the Charitable Institutions Act regarding the establishment of residents' councils. It should be stood down, again, until the substitute decision-making amendment is accepted.

The Chair: It'll be stood down. I have as well a Liberal amendment. Ms Sullivan, if you're going to present that, then it should be read into the record as well. I assume you would want to stand it down.

Mrs Sullivan: Then I think I'd better do that.

I move that section 5 of the bill be amended by adding the following sections to the Charitable Institutions Act after section 9.15:

"Residents' council

"9.16(1) If at least three persons who are either residents in an approved charitable home for the aged or representatives of residents so request, a residents' council shall be established for that home.

"Same

"(2) The residents' council shall be established and conducted in the manner provided for by the regulations.

"Member:

"(3) Each resident of an approved charitable home for the aged or, if the resident is unable to participate, the resident's representative may be a member of the residents' council and, in addition, a person selected by the resident or the representative may be a member of the residents' council.

"Same

"(4) The minister, at the request of a residents' council, may appoint no more than three persons to be members of the residents' council and those persons shall serve as members at the pleasure of the residents' council.

"Same

"(5) The persons appointed under subsection (4) shall be persons who live in the area in which the approved charitable home for the aged is located and who are not employed by and do not have a contractual relationship with the ministry.

"Same

"(6) No officer or director of an approved corporation maintaining and operating an approved charitable home for the aged and no member of the staff of an approved charitable home for the aged shall be a member of a residents' council

"Obligation of administrator

"(7) The administrator of an approved charitable home for the aged shall, within 90 days of the date on which the service agreement that relates to the home comes into effect, convene a meeting of the residents or their representatives, to advise the residents that they have the right to form a residents' council.

"Same

"(8) If a residents' council is not established in an approved charitable home for the aged after the convening of a meeting under subsection (7), the administrator of the home shall convene such a meeting at least once a year thereafter until a residents' council is established.

"Same

"(9) If a meeting is held under subsection (7) or (8), the administrator shall notify the director within 30 days of the results of the meeting.

"Same

"(10) If three or more residents of an approved charitable home for the aged or their representatives at any time express an interest to the administrator in forming a residents' council, the administrator shall forthwith notify the director of the interest and assist the residents of the home or their representatives in forming a council within 60 days of the request.

"Powers of the residents' council

"9.17 It is the function of a residents' council of an approved charitable home for the aged and it has the power to:

"(a) advise residents of the home respecting their rights and obligations under this act;

"(b) advise residents of the home respecting the rights and obligations of the approved corporation maintaining and operating the home, under this act;

"(c) meet regularly with the approved corporation maintaining and operating the home to

"(i) review ministry inspection reports,

"(ii) review the allocation of money for food, supplies and services provided by the home,

"(iii) review the financial statements of the home filed with the minister under the regulations, and

"(iv) review the operation of the home;

"(d) attempt to mediate and resolve any dispute between a resident of the home and the approved corporation maintaining and operating the home; and

"(e) report to the minister any concerns or recommendations that in its opinion ought to be brought to the minister's attention.

"Residents' council assistant

"9.18(1) The minister, with the consent of a residents' council, may appoint a residents' council assistant to assist the residents' council in carrying out its responsibilities.

"Same

"(2) In carrying out his or her duties, a residents' council assistant shall take instructions from and report to the residents' council.

"Entry not refused

"(3) No person shall refuse entry to an approved charitable home for the aged to a residents' council assistant or obstruct a residents' council assistant.

"Offence

"(4) Any person who contravenes subsection (3) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for each subsequent offence.

"Cooperation

"9.19(1) An approved corporation maintaining and operating an approved charitable home for the aged shall cooperate with the residents' council and the residents' council assistant and shall provide the information, including financial information, and assistance to them provided for by the regulations.

"Offence

"(2) Any person who contravenes subsection (1) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for each subsequent offence.

"Immunity

"9.20 No proceeding shall be commenced against a member of a residents' council or a residents' council assistant for any act done in accordance with section 9.17, unless the act is done maliciously or without reasonable grounds."

1050

The Chair: Thank you. I'm wondering, do you want to just make your comment on that so that when we do come back—

Mrs Sullivan: Yes. Basically, this proposal for the residents' council follows what is currently included in the Nursing Homes Act residents' council provisions, goes no further than that and does not reflect the approach that the government is taking with respect to substitute decisions which, in my view, is unnecessary.

Mr Jim Wilson: I just want to serve notice right now that I think both the Liberal and government amendments concerning residents' councils perhaps go a bit too far in terms of the powers and duties of the council, the power of the minister to appoint members to the council and in terms of the residents' council assistant.

I just want to serve notice that I'd like some time this afternoon, obviously, to discuss this in great length. I think a cursory view would suggest that perhaps the residents' councils may indeed, to some extent, undermine the governance of a home. I wouldn't want to see that, but I do want to make it clear we are supportive of the principle of establishing residents' councils, but perhaps these motions have gone a bit too far.

The Chair: Thank you. Both of those, then, are stood down.

Prior to moving on to the next amendments, I would ask, shall section 6 of the bill, as printed, carry? Carried.

We then move to a government motion under section 7.

Mr Wessenger: I move that the definition of "record" in subsection 10.1(1) of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding after "form" in the last line "but does not include that part of a record that deals with quality management activities or quality improvement activities."

This is provided inspectors are not entitled to have access to records dealing with quality management activities or quality improvement activities.

Mrs Sullivan: We will not be supporting this, as we have an amendment coming soon—I was just trying to find out where it is—that would also include peer review and professional review activities as excluded parts of a record for purposes of this section. I think those are important additions, and I would hope that the government would consider those.

Here we are. We have excluded solicitor-client privilege and the personnel quality review records comparable to what is included in the advocacy bill. My amendments are listed under section 7 of the bill, subsections (10.1) (5.1), (5.2) and (5.3).

The Chair: That will come up later. Thank you.

Mrs Sullivan: How would that be dealt with, in that they deal with precisely the same issue?

The Chair: That one will be amending a different subsection?

Mrs Sullivan: My amendment is section 7, subsection 10.1(5.1). I don't know why there's a difference.

The Chair: Let me just seek some assistance from the table here. While we're doing that, Mr Wilson, do you want to comment?

Mr Jim Wilson: I think Mrs Sullivan raised an excellent point. Perhaps we could have legal counsel, if it's appropriate, comment on the government motion versus the Liberal motion. The way I read it, although I don't know why they're in different sections, and I know you're asking the drafters that question, is that the difference is that the Liberal motion is more specific. To me, not being a lawyer, it's preferable but I'd like a comment.

The Chair: Mr Wilson, I wonder if I might suggest this—I will also note not as a lawyer—could I ask the government if we could defer consideration of its motion, deal with the Liberal one and then come back to the government motion? Might that perhaps allow us to work our way through this? We would deal with the Liberal section

7 of the bill, subsections 10.1(5.1) etc of the act, and then come back to yours, given that they are related. Is that all right?

Mr Wessenger: Yes, okay.

The Chair: Mrs Sullivan, would you then read your amendment into the record and we'll deal with that first.

Mrs Sullivan: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsections:

"Exception, solicitor-client privilege

"(5.1) Subsection (5) does not override any solicitorclient privilege to which a record is subject.

"Exception, law enforcement

"(5.2) An inspector is not entitled to have access to a record or part of a record whose disclosure could reasonably be expected to produce one of the results described in subsection 14(1) of the Freedom of Information and Protection of Privacy Act (law enforcement).

"Exception, personnel records, quality review etc

"(5.3) An inspector is not entitled to have access to a personnel record or to a record or part of a record dealing with.

"(a) quality review activities;

"(b) peer review or performance review activities; or

"(c) quality improvement activities."

The Chair: Would you then comment on your amendment.

Mrs Sullivan: I think the parliamentary assistant will remember that we went around the ballpark on this entire question when we were dealing with Bill 74, Bill 109 and Bill 108 with respect to when and where records should be available and when and where records should be protected.

With respect to peer review activities, it was felt that, particularly in a quality management system, the peer review records must be protected or the quality management programs will not proceed and the peer review programs will not work. This bill is unfortunately caught in a kind of limbo between the inspection system and the compliance system of enforcement. I believe through changing quality assurance to quality management, we have made some steps to ensure that quality improvement programs using a multidisciplinary team approach in each home will be brought into effect. They will not work, however, if reports that are prepared as part of peer review or performance review activities, which are integral to a quality management program, are available for inspection and can be used detrimentally against the personnel of the home.

I think the government is making a bad mistake by not including or considering the issues I have included in my amendment in its own.

The Chair: Perhaps we could just get all of these arguments on the—

Mr Jim Wilson: This may be of some unintended help to the government.

The Chair: Mr Wilson, you are always of help to the government.

Mr Jim Wilson: When I look at the Liberal motion, I have two questions. First, is it necessary to put an exception

regarding solicitor-client privilege? To me, that's redundant. That's covered in the law already. Second, the exception regarding quality review contained in the Liberal motion, the way I read the wording of the government amendment, it's more general, and upon second reading, it seems to me covers the whole gamut quite sufficiently. So I would like legal counsel's opinion on the effect of the difference between these two motions.

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Mr Wessenger: I was going to ask ministry counsel, if that was satisfactory, to respond. First of all, you're quite correct, Mr Wilson, with respect to solicitor-client privilege. It is redundant; it's protected in any event. I'll ask legal counsel to comment on peer review and also the other language, performance review activities. There's a particular reason why that would be difficult with respect to being removed, because we do have to have the power to investigate abuse situations, and the performance review activities are necessary. Also, there is a distinction from the Advocacy Act, because there is no limitation on what information may be used by an advocate, while there is a limitation for compliance with the act. With that, I'll turn it over to legislative counsel to add. Maybe I've covered most of it.

Ms Czukar: Gail Czukar, legal counsel with the Ministry of Health. I think most of the points have been covered by Mr Wessenger, but in our view, records related to peer review activities would be included in quality management and quality review activities. With respect to performance review records, inspectors of the ministry do need access at times to performance appraisals and that sort of thing, and they do need access to personnel records to verify qualifications that are required by the act and regulations.

I would just emphasize Mr Wessenger's point that access by advocates to records is very different from access by ministry inspectors. The section of the act that we've proposed includes a purpose section which says that the inspectors inspect for the purpose of determining compliance with the act and regulations. Advocates don't have that kind of limitation; they can use information for whatever purpose their client wishes. So we believe our motion does exempt the records that need to be exempted for quality management and quality review activities, and inspectors need access to the other records to determine compliance with the act and regulations.

Mr Jim Wilson: I certainly appreciate the comment. I can see inspectors needing access to personnel records. I would be a little more comfortable if we could have a marriage of these two amendments. I'd like to take it as a given, but given that this concern about including peer review activities and documentation thereof was so very often mentioned to me at meetings I had regarding this legislation and mentioned at the committee during the hearings, perhaps the government could amend its amendment to not only talk about quality management activities or quality improvement activities but also perhaps include peer review activities, just to make sure we're absolutely

clear. Then I would be very comfortable supporting the government's amendment.

Mrs Sullivan: We would support that as well, Mr Chairman

Mr Jim Wilson: The government may feel it's unnecessary, but I'll tell you, a lot of people who are actually in the field and who are expert in this are very worried about the fact that the government to this point hasn't put forward the exception on peer review.

Mr Wessenger: On advice of legal counsel, we're not prepared to include that amendment.

The Chair: I therefore put the motion by Ms Sullivan. Shall her motion carry? All those in favour? Opposed? The motion is defeated.

We will then return to the government motion, which I believe has been read into the record. We will simply put the question. Shall the government motion carry?

Mr Hope: Which one? Can you be specific?

The Chair: Sorry. Please make sure I'm correct: It's section 7 of the bill, clause 10.1(2)(b). Is that the right one?

Mr Wessenger: No. It's subsection 10.1(1).

The Chair: Oh, I'm sorry. I was looking at the Liberal one.

Let me repeat: Shall the government motion, section 7 of the bill, subsection 10.1(1), carry? Carried.

We move to another government motion.

Mr Wessenger: I move that clause 10.1(2)(b) of the Charitable Institutions Act, as set out in section 7 of the bill, be struck out and the following substituted:

"(b) may, if he or she has reasonable grounds to believe that the records or other things pertaining to an approved charitable home for the aged are kept in a place that is not in the home, enter the place at all reasonable times in order to inspect such records and other things."

This amendment adds a new requirement that an inspector should have reasonable grounds to believe the records of the home are kept offsite in order to enter and inspect premises.

Mr Jim Wilson: I'm sorry, I didn't hear the last part of your explanation.

Mr Wessenger: We basically require reasonable grounds, which is the normal provision, with respect to entering. I believe it's the test for warrant as well.

The Chair: Shall the government motion carry? Carried.

Ms Sullivan, yours is the next one.

Mrs Sullivan: I move that clause 10.1(2)(b) of the Charitable Institutions Act, as set out in section 7 of the bill, be struck out and the following substituted:

"(b) may, under the authority of a warrant issued under section 10.1.1, enter a place in which records or other things pertaining to an approved charitable home for the aged are kept, in order to inspect such records and other things."

This may become redundant, as the government motion moves ahead with respect to a warrant. This leaps ahead, I think, so I'll stand it down until the government reaches its motion. The Chair: Deferred?

Mrs Sullivan: Yes

Mr Jim Wilson: Do the Liberals not have another (2)(b)?

Mrs Sullivan: Yes, which I'm not putting forward.

The Chair: That second one is withdrawn. Then the Conservative motion.

Mr Jim Wilson: I move that subsections 10.1(2) and (3) of the Charitable Institutions Act, as set out in section 7 of the bill, be struck out and the following substituted:

"Inspection of approved charitable home for the aged

"An inspector may at all reasonable times enter and inspect an approved charitable home for the aged, for the purpose of determining whether there is compliance with this act, the regulations or a service agreement."

I just want to comment that inspectors will have considerable power under this act. This amendment seeks to ensure that inspections are carried out at reasonable times and only in places that should concern the inspector. Any areas not covered in the legislation are of course open for inspection should the inspector have the necessary warrant from a justice of the peace. For this reason, the wide powers under this section can and should be limited somewhat, and that's the purpose of this amendment.

Mr Wessenger: We'll be voting against this motion because we've already put in a provision about reasonable grounds with respect to offsite, which Mr Wilson voted in favour of; also, in many cases the records are at head office, and we don't want to eliminate the right of the inspector to attend at offsite locations such as head offices.

The Chair: Shall the government motion carry? All in favour?

Mr Wessenger: No. it's not a government motion.

The Chair: I'm sorry, shall Mr Wilson's motion carry? I'm really getting confused here. All in favour? Opposed? Defeated.

We then move to a Liberal motion.

Mrs Sullivan: I won't be putting this one forward.

The Chair: Mr Wilson.

Mr Jim Wilson: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsection:

"Limitation on inspectors' powers

"(5.1) Subsection (5) does not give an inspector the authority to conduct an examination or test on an individual."

Even though the expression "tests and examinations" represents common legal terminology, I propose it be clarified, as it implies something different in the medical field. My amendment would ensure that inspectors could carry out their duties within their field while not being able to cross over the line into other terrain which is perhaps medical. It has been brought to my attention that it would be preferable to clarify the language surrounding the term "examination" to ensure that inspectors are limited to non-medical examination. That's the intent of this amendment.

Mr Wessenger: We will not be supporting that, because basically what we're concerned about is an abuse

case. I think it's fair to say that you couldn't have a personal examination of an individual without that person's consent in any event; it would be an assault if you had such a situation. So the person's consent would, by common law, be required for any test or examination of any type. I'm just concerned that this motion might prohibit such examinations, even with the consent of the person, so for that reason, I will be voting against it.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? The motion is defeated.

We then move, Mr Wilson, to your next amendment.

Mr Jim Wilson: I move that subsection 10.1(12) of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by inserting after "at the inspector's request" in the fourth and fifth lines, "and at a time that is mutually agreed upon".

The addition of this phrase at the end of that paragraph, the phrase being "and at a time that is mutually agreed upon," simply acknowledges that other professionals' schedules must be respected. For instance, health care professionals may be required to produce things or assist inspectors as a result of this clause. It seems to me that this would add some goodwill to this clause and, while compliance by the required health care professionals is not in question, it would simply try to ensure that convenience is respected.

Mr Wessenger: We will not be voting in favour of this amendment because there is concern that it could in effect negate the whole process.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? It is defeated.

Mr Wilson, yours is the next one.

Mr Jim Wilson: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsection after subsection (12):

"Reimbursement of expenses

"(12.1) The minister shall reimburse an approved corporation for all extraordinary expenses incurred in the preparation, production and interpretation of records of an approved charitable home for the aged for an inspector."

The Chair: Mr Wilson, I'll have to rule this out of order under section 56.

Mr Jim Wilson: May I say that I'm not surprised that you ruled it out of order.

The Chair: The next one will be the government motion.

Mr Wessenger: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsection:

"Inspection report

"(15) Upon completing an inspection under this section, an inspector shall prepare an inspection report and shall give a copy of the report to the approved corporation maintaining and operating the home."

This really requires the inspector to make an inspection report after completing the inspection, and it's a precondition for the posting requirement. Mr Jim Wilson: Members will note the next PC motion is very similar except that the PC motion is a little more detailed. I believe homes should be fully informed of the inspector's finding, so I agree with the intent of the government's amendment in that regard. The inspectors should be required to advise the facilities of their findings in order that the appropriate changes can be made promptly.

I would ask the government to just comment on what perhaps the parliamentary assistant doesn't like about the PC motion, even though it's not on the table at this point, given that I think it's a better motion than the government motion.

Mr Wessenger: I'd be very happy to comment on that. In fact, the reason for our preference for our motion is that "Upon completing an inspection" is much earlier than "Within thirty days." That means it should be done, in effect, immediately upon the completion of the report. We think the information should be available as quickly as possible.

Mr Jim Wilson: If I may, perhaps I could ask what the current practice is then. It's my understanding—please correct me if I'm wrong—that the intention now is to inform homes upon completion of an inspection, but that this often doesn't take place or can often not take place for many, many days after the inspection. In fact homes aren't even aware whether the inspection is complete or not; therefore, the 30-day time line is to ensure that all parties concerned know the time framework involved.

Mr Wessenger: I'll ask legal counsel just to comment on that.

Ms Czukar: This is really a question of ministry practice but, in the absence of my colleague Mr Quirt, I'll just say that our understanding is that inspectors complete a report, including the requests for corrective action by the home, and leave it with the home when they leave after completing the inspection. So the reports are effectively done immediately.

Mr Jim Wilson: There's a second point that I'd also like a comment upon. You'll note that the PC motion is more specific in terms that it requires the inspector to report "all findings, conclusions and recommendations to the administrator of the approved charitable home for the aged." The reason for that is that I'm told that from time to time inspectors don't report all findings, that is, including all the notes they may make in an addendum to the report.

Homes will then find that another inspector will come along later and say, "You never corrected X, Y and Z of the previous inspection report." The administrator of the home will say, "Well, I never heard about these problems," and they'll say, "Well, it's right here in the inspector's working copy of the report." The administrator will say, "But those findings were never conveyed to me."

They find that when they change inspectors, and when there's inconsistency on behalf of the government, it can be problematic. This requirement would say you've got to disclose everything, and with the next inspector along, everybody knows the playing field that we're dealing with.

I'm only bringing this concern forward on behalf of administrators and so on because I believe they have some real-life examples where this has happened to them, and with moving to a contractual service agreement arrangement, it becomes very clear that all parties are sure where they stand at the end of an inspection.

Mr Wessenger: I take your comments, and certainly they should be passed on to the administrator.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried. Mr Wilson.

Mr Jim Wilson: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsection:

"Inspection report

"(15) Within thirty days of completing an inspection under this section, an inspector shall"—

Mr Hope: Excuse me, just a point of procedure. How can you read that motion when we've just amended that section?

The Chair: He can read in his motion. It can't carry, but he can read it into the record.

Mr Jim Wilson: And you can vote on it.

The Chair: We'll have to vote on it.

Mr Hope: Why do we have to vote on it when we've just amended that section?

Mr Jim Wilson: We don't presuppose anything.

Mrs Sullivan: It's a democracy.

Mr Hope: I'm asking for a point of clarification from the Chair on procedural aspects. We just amended (15).

The Chair: Procedurally he may read his motion into the record and I will simply ask for a vote on it.

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Mr Hope: But I'm asking under procedural. We just amended that (15) and now we're putting another amendment on (15)?

The Chair: Well, it is in effect another amendment, which presumably, given the vote previous, will not carry.

Mr Hope: I don't agree, but okay.

Mr Jim Wilson: We don't like to be presumptuous.

Mr Hope: Yes, but I can't challenge the Chair, so I have to agree with him.

Mrs Sullivan: It is a democracy, Randy.

Mr Jim Wilson: Mr Hope may want to note that that has happened—it's very good of him to bring that point up, but it has happened several dozen times.

Mr Hope: Okay.

Mrs Sullivan: Come on, let's go.

Mr Jim Wilson: I move that section 10.1 of the Charitable Institutions Act, as set out in section 7 of the bill, be amended by adding the following subsection:

"Inspection report

"(15) Within thirty days of completing an inspection under this section, an inspector shall submit a full report of all findings, conclusions and recommendations to the administrator of the approved charitable home for the aged."

Mr Chairman, my previous comments stand. I think this clause deserves more serious consideration than has been given it by the government and I would ask for a recorded vote.

The Chair: Shall Mr Wilson's motion carry? And a call has been made for a recorded vote. All those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Navs

Hope, O'Connor, Perruzza, Wessenger, Wiseman.

The Chair: It is defeated. We then move to government motion 10.1.1.

Mr Wessenger: I move that section 7 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 10.1:

"Warrant

"10.1.1(1) A justice of the peace may issue a warrant authorizing an inspector named in the warrant to enter premises specified in the warrant and to exercise any of the powers mentioned in subsection 10.1(5), if the justice of the peace is satisfied on information under oath that,

"(a) the inspector has been prevented from exercising a right of entry to the premises under subsection 10.1(2) or has been prevented from exercising a power under subsection 10.1(5); or

"(b) there are reasonable grounds to believe that the inspector will be prevented from exercising a right of entry to the premises under subsection 10.1(2) or will be prevented from exercising a power under subsection 10.1(5).

"Expiry of warrant

"(2) A warrant issued under this section shall name a date on which it expires, which date shall not be later than thirty days after the warrant is issued.

"Extension of time

"(3) A justice of the peace may extend the date on which a warrant issued under this section expires for an additional period of no more than thirty days, upon application without notice by the inspector named in the warrant.

"Use of force

"(4) An inspector named in a warrant issued under this section may use whatever force is necessary to execute the warrant and may call upon a police officer for assistance in executing the warrant.

"Time of execution

"(5) A warrant issued under this section may be executed only between 8 am and 8 pm, unless the warrant specifies otherwise.

"Other matters

"(6) Subsections 10.1(4) and 10.1(6) to (15) apply with necessary modifications to an inspector executing a warrant issued under this section."

I think this is quite self-explanatory. It permits an inspector to obtain a warrant in the event he or she is denied entry. Mrs Sullivan: We have an amendment which also would introduce warrants into the bill, and when I read our proposals side by side with those of the government, I want to make a couple of observations.

One of them is that our amendment would indicate that the inspector could call on the police officer for assistance in executing the warrant where that's necessary. The government goes much more jackbooted, if you like, into this situation by indicating that the inspector may use whatever force is necessary and then also may call on a police officer. In our view, that's overkill; the execution paragraph from our proposal is more acceptable and we would prefer to see that there.

Additionally, just looking at the duration here, I believe that we both have extension of the—no. We don't both include the extension of the warrant, but the proposal we have put forward is that the warrant would be valid for a shorter period of time. Then presumably an extra application should be made. The warrant, under the government's proposal, would last for 30 days, and then a subsequent 30 days seems to us to be too extensive a length of time.

Mr Jim Wilson: I just have a question of the parliamentary assistant. What's the current practice concerning warrants issued by a justice of the peace and sought by inspectors?

Mr Wessenger: What's the existing practice?

Mr Jim Wilson: Yes. I don't remember getting into great detail during the hearings about this practice, so I wouldn't mind if there was an explanation of what the current practice is.

Ms Czukar: This provision responds largely to a request by the Ontario Medical Association that if inspectors required production of documents from physicians in their offices, there be an option for the doctor to require a warrant to be produced rather than a simple written production, which is the current requirement and right of the inspector under the provision in the bill. So this is a provision that responds basically to that request. It's a complete warrant provision that contains all the rules. It's not contained in any of the acts right now.

Mr Jim Wilson: My memory isn't good enough to recall verbatim what the requirements are in the warrant provisions of the advocacy and consent legislation. Does this conform to that?

Ms Czukar: Yes, this was modelled on that. We did take it from the Advocacy Act to the extent that it was applicable.

Mr Jim Wilson: Finally, I just want to comment on the fact of use of force by an inspector. Unlike Mrs Sullivan, I don't have any particular problem with that. There's no use issuing a warrant if you can't take every reasonable means to enforce the object of the warrant, and I'll be supporting the government amendment.

Mrs O'Neill: I certainly have difficulty with this. What does the government mean by "use whatever force is necessary" and why are the hours 8 am to 8 pm? There must be reasons. They are certainly beyond normal working hours. We're talking here about institutions that have

vulnerable people within them. I have difficulty with the extension and this hanging over people's heads for 30 days. I like our amendment much better with seven.

There were many, many complaints throughout the entire set of hearings about this whole sanctions, force, confrontational approach to inspection. Here I have to use the same words as Mrs Sullivan: We get a very jackboot approach, and I just don't think this is going to engender the best relationships within people. So could the government tell us what it means by "use whatever force is necessary," if that does not include a police officer, and why does it have to be 8 am to 8 pm?

Mr Wessenger: I think, as indicated earlier, it was modelled upon the Advocacy Act. It's purely a judgement matter what appropriate hours for executing a warrant are. I suppose it's normally felt that those hours are normal hours and you're not going to disturb people in their sleep etc.

Mrs O'Neill: The right people may not be present at 8 pm.

Mr Wessenger: I think it's fair to say that particularly with doctors' offices, many of them may be open between those hours of 8 am and 8 pm. There would be not much sense in somebody going for the warrant when no one was there, quite frankly.

Mrs O'Neill: That's my point.

Mr Wessenger: Of course force, as Mr Wilson indicated, is a normal provision. It's always in that if you can't take the appropriate level—there are common-law protections with respect to health and what is done. It's not an unlimited right.

The Chair: Shall the government motion carry? Carried.

Ms Sullivan, did you-

Mrs Sullivan: I'll not put my motion forward, Mr

On a point of order, Mr Chairman: I wonder if we could take a three- or four-minute break now and then come back?

Mr Hope: Is that why you're jumping?

Mrs Sullivan: No, we have some amendments to review.

The Chair: We will recess for three minutes.

The committee recessed at 1131 and resumed at 1136.

The Chair: The committee will reconvene. We move to the government motion to section 10.3.

Mr Wessenger: I move that section 7 of the bill be amended by adding the following section to the Charitable Institutions Act after section 10.2:

"Protection from reprisals

"10.3(1) No person shall do anything, or refrain from doing anything, in retaliation for another person making a disclosure to an inspector, so long as the disclosure was made in good faith.

"No interference

"(2) No person shall seek, by any means, to compel another person to refrain from making a disclosure to an inspector.

"Offence

"(3) Any person who contravenes subsection (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for each subsequent offence."

This amendment provides protection from reprisals to anyone who discloses information to an inspector and makes it an offence to retaliate or compel someone not to speak to an inspector.

The Chair: Any comment? Mrs Sullivan: We concur.

Mr Jim Wilson: This would be the whistle-blowing section. I don't particularly have any problem with it, other than that I question how far the prohibition would apply. For instance, what does it really mean: "do anything, or refrain from doing anything, in retaliation for another person making a disclosure to an inspector"?

For instance, if somebody were to give an inspector personal information—we've already prohibited, by example, that you can't have the posting of salaries and that sort of thing. The inspector would have access to that, but given the peer review stuff, for instance—that would be a better example—if someone were to disclose information contained in peer review activities, would they still be covered under this whistle-blowing legislation and would they still enjoy immunity, as it were?

Mr Wessenger: I think the limitation is, as long as the disclosure was made in good faith.

Mr Jim Wilson: I realize that's legal terminology and a catch-all. I guess we won't debate it here; I'll take your word that this has been well-thought-out by the government.

It just seems to me that while whistle-blowing is necessary—and a certain amount of it goes on now, in that people have the right to approach their member of provincial Parliament, and do from time to time, regarding concerns they have with administration in homes—I just want to make the final comment that it's kind of a sad day when you have to put whistle-blowing provisions in legislation. I think people should feel free, in a democracy, to approach their MPP. I get disturbed by this type of legislation, because to me it erodes credibility and the role of elected politicians. While I'll support it, I just want to put on the record that I have reservations about it.

Mr Wessenger: I just might make a comment on this whole question. This only provides protection to the person who does the initial whistle-blowing. I think people should be aware that anybody who passed on public disclosure of any of that information that was incorrect could have legal liability. For instance, an MPP, to give an example, provided with incorrect information who then makes it public other than in the House, could find himself or herself with civil liabilities.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

We move to section 8, a government amendment.

Mr Wessenger: I move that clause 11(1)(c) of the Charitable Institutions Act, as set out in section 8 of the bill, be amended by:

(i) striking out "is in contravention of" in the second and third lines of subclause (i) and substituting "has contravened": and

(ii) striking out "is in breach of" in the second and third lines of subclause (ii) and substituting "has breached".

This amendment allows the minister to revoke approval for a previous and recurring contravention of the act or the regulations and previous and recurring breaches of the service agreement. I think it's the same rationale as we had with respect to a previous amendment.

Mrs Sullivan: Once again we will not be supporting this amendment. We feel that the homes are left in the impossible situation of being faced with charges or reduction of funding for an incident that could merely be a technical breach or that may have occurred substantially before and around which records have been lost and/or where corrections have been made.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 8 of the bill, as amended, carry? All in favour? Section 8 is carried.

We then move to section 9 and begin with the Conservative amendment.

Mr Jim Wilson: I move that clause 12(b.2) of the Charitable Institutions Act, as set out in subsection 9(1) of the bill, be struck out and the following substituted:

"(b.2) governing applications to placement coordinators for a determination, including prescribing the placement coordinators to whom applications may be made and the frequency with which applications may be made."

This is simply a clause amending regulation-making powers, an attempt to clarify—and I think improve upon to a certain extent— what currently exists in (b.2) of the legislation.

Mr Wessenger: We'll not be voting for this amendment because it would not provide, in our opinion, enough flexibility in the interim situation until we have the whole, final placement coordination process.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

We then move to the Liberal motion.

Mrs Sullivan: I think the government has a motion before mine.

The Chair: Yes, it does. Do we have a new yellow page? Is this different? Sorry, we have some coloured sheets here. I just want to make sure we're singing from the same hymn-book.

Mr Wessenger: I think they start with 18(5). This one's okay.

The Chair: Everything is copacetic. Mr Wessenger, would you move your amendment, please?

Mr Wessenger: I move that clause 12(b.4) of the Charitable Institutions Act, as set out in subsection 9(1) of the bill, be struck out and the following substituted:

"(b.4) prescribing, for the purpose of clause 9.5(8.5)(c), additional circumstances which are grounds for an approved corporation to withhold approval for the

admission of a person to an approved charitable home for the aged;

"(b.4.1) prescribing and governing the obligations of an approved corporation in relation to giving or withholding approval for the admission of a person to an approved charitable home for the aged, and governing the written notice required to be given under subsection 9.5(8.6)."

This is a regulation-making power and the wording's been changed to reflect changes in subsection 9.5(8.5).

Mrs Sullivan: We'll be supporting this amendment and not be putting forward the amendment which follows. We feel that this is an important change to the regulations under the act in that homes will be able to have input into whether or not they can serve the person whom a placement coordinator would otherwise, had this change not been made, have dropped upon them. So we are strongly in favour of this motion. We feel that it's a significant improvement.

Mr Jim Wilson: I too want to indicate my support for this government amendment, and I want to give an opportunity for the parliamentary assistant to assure members of provincial Parliament and the public that homes themselves will be very much part of the process in drafting these regulations, now that we're into the regulatory-making powers of the act, particularly this one, which extends the grounds for which an approved corporation can withhold approval for admission.

Consumers' rights and facilities' rights are something we had a lot of talk about, of course. I'd just like the parliamentary assistant to give us the assurance that the homes themselves are fully incorporated into the consultation leading to the drafting of the regulations.

Mr Wessenger: Yes, we will be consulting with them.

Mr Jim Wilson: Don't go out of your way.

Mrs Sullivan: We want that in writing.

Mr Jim Wilson: It's discomfiting to know that the parliamentary assistant in no way wants to go out of his way to assure the public that—

Mr Wessenger: The best answer is a yes or no.

The Chair: And I think the answer was yes.

Shall the government motion carry? All in favour? Opposed? Carried.

The next one: I would ask you to turn to the yellow sheets, as opposed to the white one that you have. Mr Wessenger, would you—

Mr Wessenger: Yes.

The Chair: Has everybody got that?

Mr Jim Wilson: There's a lot of yellow.

The Chair: There's a lot of yellow.

Mr Wessenger: It's very short.

The Chair: It is short and it's the second page of one of the yellow bundles.

Mr Hope: Third page.

The Chair: Sorry, third; quite right. These are tests that we all go through. Mr Wessenger, if you'd read that.

Mr Wessenger: I move that subsection 9(1) of the bill be amended by adding the following clause to section 12 of the Charitable Institutions Act, after clause 12(b.4.1):

"(b.4.2) requiring that placement coordinators have certain qualifications or meet certain requirements and prescribing such qualifications or requirements."

The Chair: Mr Wilson?

Mr Jim Wilson: Perhaps Mrs Sullivan should go, but I do think there was a Liberal motion similar to this stood down.

The Chair: Yes.

Mr.Jim Wilson: Maybe we should deal with that.

Mrs Sullivan: Mr Chairman, as I recall, the motion that I made was not stood down. In fact, it was one of the opposition amendments that was accepted, as I recall, indicating that placement coordinators should be qualified and—

Mr Jim Wilson: No. It was stood down. I specifically remember commenting on it.

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Mrs Sullivan: All right.

The Chair: Could you just give us the number?

Mrs Sullivan: Section 5, 9.5(2.2).

Mr Wessenger: I think I should, just for clarification, indicate that we will be voting against that amendment because we don't want to disqualify existing placement coordinators by virtue of—

Mrs O'Neill: I'm sorry, can you speak a little louder?

Mr Wessenger: I just said we'd be voting against the motion that was stood down on section 5 on the basis that we don't want to disqualify existing placement coordinators.

Mrs Sullivan: Mr Chairman, that is shocking. What the parliamentary assistant has just described to us then is the circumstance whereby we could have placement coordinators who are designated by the minister who are not qualified to do the job that they are to do.

Mr Wessenger: No, the problem with that amendment—I haven't got it in front of me, but I think the word "unless"—what we're doing is we're putting in this provision to have enabling legislation to give us the authority to bring in those qualifications and bring in requirements. But the original motion in effect would—"no person or entity may be designated unless the person..." Until we have the qualifications set out in the regulations, we have an automatic disqualification.

The Chair: Just so people understand what we are discussing, the second one is subsection 9.5(2.2), if you're looking for it in your material.

Mrs Sullivan: My motion was part of a two-part approach to this, one of them, which is the motion which is now stood down, saying that no person can be designated unless they're qualified. The second part is a motion, which is the next after the next government motion, which says that the minister shall prescribe the qualifications for persons and entities to be designated. The two parts work hand in hand. The second one of my motions does precisely what the government's motion does in this case. The

first one says nobody can act unless they meet those regulatory requirements.

Mr Jim Wilson: I would just ask the clerk for a copy of the Liberal amendment 9.5(2.2), the stood-down motion. I just can't find my copy at the moment.

The Chair: Okay, we'll make that available. Shall we then put the government motion, clause 12(b.4.2)? Shall the motion carry? All those in favour? Opposed? The motion carries.

Mrs O'Neill: Mr Chairman, while we're just sorting out the paper, could I have for sure from the parliamentary assistant that the reason he has difficulty with our amendments is he's worried about automatic disqualification? Is that the crux of the matter?

Mr Wessenger: What we are basically concerned about is that, first of all, under that amendment, although we're discussing an amendment that's not in front of us now, until you had regulations in effect, you would not have any placement coordinators under the act, because you'd have to have those qualifications established. What we want to do is to first of all have placement coordinations across the province.

The Chair: I'm sorry, I must—

Mr Wessenger: Yes, we're out of order.

The Chair: We're out of order. We will be coming back to that. It was stood down. The next motion then is the government motion 12(b.6).

Mr Wessenger: I move that clause 12(b.6) of the Charitable Institutions Act, as set out in subsection 9(1) of the bill, be struck out.

This also should be stood down on the basis of substitute decision-making.

The Chair: Okay, this will be stood down. The government motion is next.

Mr Wessenger: Clause 12(k.1).

The Chair: Sorry, I've got a Liberal motion before that, Mrs Sullivan, clause 12(b.7).

Mrs Sullivan: This is redundant since the government motion with respect to the regulations has passed.

The Chair: All right. Mr Wessenger.

Mr Wessenger: I move that clause 12(k.1) of the Charitable Institutions Act, as set out in subsection 9(5) of the bill, be struck out and the following substituted:

"(k.1) requiring that parts of the bed capacity of approved charitable institutions or a class of approved charitable institutions be set aside for various classes of accommodation, and regulating the amount of bed capacity that must be set aside for each class."

This is required in order to classify accommodation, I assume, with respect to short-term and long-term beds.

Mr Jim Wilson: I gather the change to clause (k.1) is also to accommodate what the government has finally come around to, that is, giving a little more assurance to Canada's veterans. While you're going to classes without being specific, the original clause (k.1) talked about shortstay and preferred accommodations. Perhaps we could have a little more detailed explanation of the difference

between the original clause (k.1) and the new amendment. Are not veterans' beds becoming a class of beds? Have I got that wrong? I just took a cursory look at the next amendments.

Mr Wessenger: I don't think they become a class of beds under the act. Those are basically under federal jurisdiction in a sense.

Mr Jim Wilson: I'm sorry, I don't understand the effect of the change.

Mr Wessenger: This is only for the short-term and long-term classes, the money that you can charge. In other words, to set aside a varying rate for respite care beds as distinct from the long-term care beds. That's the purpose of the regulation.

Mrs Sullivan: There are several motions with respect to what capacity should be set aside or what capacity should be funded. The words are being changed from "short-stay accommodation" to "short-stay program" etc. The problem with this change is that what the government is doing is taking out the setting aside of bed capacity for basic accommodation and moving short-stay accommodation requirements into a different section, now calling it a program. So they're basically moving from the bed emphasis to the program emphasis, but the basic accommodation now is out of the bill. There are various classes under clause (k). If you read this in comparison to clause (k.1). which is being struck out, parts of the bed capacity set aside for basic accommodation, that's out; parts of the bed capacity for short-stay accommodation, that's out. The basic accommodation is not included anywhere else in the rest of the government's amendments.

Mr Wessenger: I will ask legal counsel to clarify this point.

Ms Czukar: The point is clarified if you look at the amendment that was made to 9.3. It strikes out "basic accommodation" and adds "a class of basic accommodation," so that we now have classes of basic and preferred accommodation. That's why clause (k.1) now refers to classes of accommodation, because we can have both classes in basic and in preferred accommodation. It relates to being able to set different rates in regulation for short-stay and long-stay basic accommodation as well as different classes of preferred accommodation because, as was mentioned under 9.3, we might want to set different rates for short-stay from long-stay accommodation in basic as well as in preferred.

1200

Mrs Sullivan: Where is the amendment to 9.3?

Ms Czukar: It was carried 9.3(1)(a). It was made in the act, so this is a change to the regulation-making power in order to be able to give effect to what we did in 9.3.

Mr Jim Wilson: It does beg the question, though, because it comes up in future government amendments., What is a short-stay program then? Just because we're talking about short-stay accommodation, what's a short-stay program, because I haven't seen that?

Mr Wessenger: I will ask ministry staff to indicate what it is.

Mr Quirt: The short-stay program involves providing beds in facilities that would allow facilities to respond to the need for emergency respite care if someone needs to go in for a weekend because care givers are caring for the person at home and need an emergency break from their responsibilities.

Another example of the short-stay program would be planned respite care program, where clients and their families would pre-arrange for the person receiving care to be in the facility for a week so that the care givers might have a vacation.

The other category of short-stay program is convalescent care. If someone, for example, leaves the hospital after having a hip operated on and needs the support of a long-term care facility for a period of three or four weeks while he or she recuperates and then moves home, we would also call that an example of a short-stay program. In recognition of the lifestyle cost that families have in maintaining their residence in the community while they are only in the facility for a short period of time, it would be our intention to have a reduced rate apply for care in the facility, given that it isn't the permanent home of the resident and that they still have to meet lifestyle costs in the community.

Mrs Sullivan: Just for confirmation here, I understand that homes are now operating at about 96% occupancy and it's anticipated they're going to go up to 99% occupancy with this bill without respite care beds being set aside. Where are those beds going to come from?

Mr Wessenger: Perhaps I'll again ask ministry staff.

Mr Quirt: Currently in the nursing home program, my understanding is that the occupancy level is higher than that.

Mrs Sullivan: It's about 96.8%.

Mr Quirt: In the homes for the aged program, there are roughly 1,100 beds in residential care that are now empty. They are empty as a result of our current charging practice for residential care and the needs test associated with that and often the high fee charged to residents, sometimes \$60, \$70, as high as \$90 a day for care in those beds. Often those beds are in unattractive ward accommodation compared to semi-private or private accommodation.

We expect with the new income-tested user fee that those beds will be filled fairly rapidly because there won't be that disincentive to occupying those beds. Each facility will have an occupancy target established, based on the demand for respite care in that particular facility, and that target can be established not only to provide for the normal flow of residents through the facility, but to allow for one, two or three or how ever many beds are required in each facility to meet the demand for respite care, and adjusted depending on whether those beds are used to the fullest potential. If respite beds go unused, then we would increase the expectation for that facility to fill them with permanent residents.

The Chair: I think we're going to have to put the question. Shall the government motion carry? All in favour? Opposed? Carried.

Mr Jim Wilson: I don't want to put staff to a great deal of bother, but I have a feeling this request may be a bit onerous. I would like, before we go into third reading in the House on this legislation, to have a clearer picture of what the classes of accommodation will be after this legislation is in effect, and a better explanation of short-stay programs.

I don't recall, during the hearings, learning about or having comment and input on all these different fees and levels of charges that we now hear are coming out in the regulatory powers. I think consumers have a right to know what the future of long-term care facilities, ie, the nursing home sector, are going to look like. I'd like a fairly comprehensive explanation of the lay of the land after this legislation takes effect. I need that obviously, and I think all members need that, before we go into third reading.

The Chair: Thank you, Mr Wilson. We now move on to the next amendment, a government amendment.

Mr Wessenger: I move that clause 12(1.1) of the Charitable Institutions Act, as set out in subsection 9(6) of the bill, be amended by striking out "and 'short-stay accommodation" in the third and fourth lines, and substituting "short-stay program and 'veteran'."

The Chair: Everybody realizes that's a yellow sheet? Shall the government motion carry? All in favour? Opposed? Carried.

I then have a Progressive Conservative one.

Mr.Jim Wilson: Is it 12(1.1)?

The Chair: Yes.

Mr Jim Wilson: I won't be introducing that.

Mr Anthony Perruzza (Downsview): On a point of order: On the last motion, I know that we voted and I know that the Conservative caucus voted, but I didn't see the Liberal caucus vote and I don't know whether it's for or against.

The Chair: It was carried.

Mr Perruzza: I understand it was carried.

The Chair: It was not a recorded vote. It was carried.

Mr Perruzza: Well, then, that's fine.

The Chair: The next motion is a government motion.

Mr Wessenger: I move that clause 12(1.2) of the Charitable Institutions Act, as set out in subsection 9(6) of the bill, be struck out and the following substituted:

"(1.2) Prescribing the maximum amounts or governing the manner of determining the maximum amounts that may be demanded or accepted from or on behalf of a resident under clauses 9.3(1)(a) and (b), prescribing the information or proof that is to be provided before a determination is made, requiring that the information provided for the purpose of a determination be provided under oath and prescribing the persons or other entities who may make the determination.

The Chair: Any comments?

Mr Jim Wilson: Just one moment.

Mr Wessenger: This does provide more specific regulation to make authority regarding income testing, which is needed if information is to be required under oath.

The Chair: Mrs Sullivan.

Mr Hope: Mr Chairman.

The Chair: Sorry, just before you begin, Ms Sullivan,

Mr Hope: Just a point of clarification. Did he say "1.2" or "1.2"? Because my paper says "1.2."

The Chair: I thought it was a 1, but it is evidently an "1."

Mr Hope: It's an "l"? The Chair: Yes.

Mr Wessenger: I thought it was too, but-

The Chair: Sometimes an "l" and a 1 look similar. Ms Sullivan, sorry. Would you go ahead with your comments?

Mrs Sullivan: I'm wondering what the government's rationale is that the information has to be taken under oath, which is the singular change here.

Mr Wessenger: Yes. It's the ability to require it be made under oath; it doesn't necessarily mean it'll have to be made under oath.

Mrs Sullivan: It says, "requiring that the information...be provided under oath."

Mr Wessenger: I'll ask legal counsel, then, just to—

Ms Czukar: This is a regulation-making power, so it's a permissive section that we may make regulations to require information regarding income, for example, to be given under oath where we're doing income testing. In that event, we have to be very specific about the kind of information we would require and that would have to be spelled out in the regulation as well.

1210

Mr Jim Wilson: I, too, wanted to question that because now, I guess, the answer is that this is a sort of routine way of doing things, in requiring that it be taken under oath or may require that the information be taken under oath. I thought that with the income means testing the government intends to do under this legislation, you would actually be requiring a sharing of information from the federal government to ensure you are getting accurate information regarding income supplements persons may be receiving from the federal government, because this is tied to the guaranteed income supplement, the income means test, is it not?

Mr Wessenger: The answer is that there may be some people who we can't get—this information is not relevant; there will be some other circumstances that will involve an income testing which will not be related to the aspect of the information from the government, particularly those with—I think perhaps one of the exception areas I'm aware of is the spousal situation, for instance. I don't believe you need any more elaboration.

The Chair: Shall the government motion carry? All in favour? Carried.

We move to the next government motion. Mr Wessenger.

Mr Wessenger: I move that clause 12(r) of the Charitable Institutions Act, as set out in subsection 9(8) of the bill, be amended by:

- (i) adding, after "other" in the last line of subclause (i), "documents and": and
- (ii) striking out "and" at the end of subclause (i) and adding the following subclause after subclause (i):
- "(i.1) requiring that the information provided by the approved corporation for the purpose of the reconciliation be provided under oath, and."

This again is, I think, the rationale similar to the previous motion

The Chair: Any comment?

Mr Jim Wilson: Mr Chairman, the individual who was so worried about individuals voting before isn't even in the room, so I don't know whether to be insulted or to just—

Mr Hope: I request a recess.

The Chair: Okay, we'll recess for a moment.

Interjections.

The Chair: The committee will reconvene. Shall the government motion carry? All in favour? Opposed? Carried

The next motion is a Conservative motion.

Mr Jim Wilson: I move that subclause 12(r)(i) of the Charitable Institutions Act, as set out in subsection 9(8) of the bill, be struck out and the following substituted:

"(i) requiring the approved corporation to provide, at specified intervals, proof of maintenance and operating costs, information about the financial affairs and the level of occupancy of the home and other information, and."

Mr Chairman, the change here is quite significant. It's been brought to my attention that the way Bill 101 is currently drafted, the wording in (r)(i) requires and has required, I understand, for quite some time, audited financial statements from homes. I'm told that although the ministry has insisted over the years on asking for audited financial statements, some home operators tell us that the ministry personnel don't need an audited financial statement.

Members all know the cost that can be incurred when you have to ask for audited financial statements. Our own riding associations are required to produce those every year, and it can get to be quite substantial if there are any problems.

So my motion simply talks about the financial affairs of the home. It's my understanding that the government should be friendly to this amendment, because its inspectors and the home operators know what financial affairs information is needed, and it is not an audited financial statement. The cost of putting together an audited financial statement every time the government wants one can be up to \$50,000, I'm told, when you've got to pay chartered accountants to do it and to stamp it; and much of the information contained therein may contain information about an operator's other financial affairs that are related to maybe the holding company that is the owner of the home or will contain a great deal of detailed information that the government doesn't want, has never wanted, that the inspectors can live without.

I'm just wondering if we can't take this opportunity to have a comment from the parliamentary assistant regarding

this, because this has been hammered home to me so many times that I think it's a very important concern.

Mr Wessenger: I'd be very pleased to comment on that. First of all, we should remember that this is a regulation-making power, which means it's permissive, and permissive means "may." I think it's very important that we retain the right to require audits. I think you have to have that right.

The Chair: Shall Mr Wilson's motion carry? All those in favour? Opposed?

Mr Jim Wilson: Could I have it recorded? Is it too late for a recorded vote?

The Chair: Too late. Mr Wilson, yours is the next one.

Mr Jim Wilson: I move that clause 12(s.1) of the Charitable Institutions Act, as set out in subsection 9(8) of the bill, be struck out and the following substituted:

"(s.1) governing service agreements, including the replacement and cancellation and including prescribing provisions that must be contained in all service agreements and matters that must be provided for in all service agreements."

I think the important part is that this amendment speaks to the cancellation of service agreements. Again, it's a matter that's been brought to our attention by those in the know, experts and people who are subject to this legislation, that it would be very helpful that the legislation be very clear in its wording as to the status of service agreements. This is just one more amendment in which we attempt to make it clear that members know the status of the service agreements without any question at all and that requirement be thereof. I'd ask for a recorded vote on this amendment.

Mr Wessenger: If I might just comment, we'll be voting against this because, on the advice I've received, this is a redundant provision. Under our current provisions we're allowed to do this.

The Chair: Mr Hope.

Mr Hope: Mr Chairman, before the recorded vote, I ask for a recess for a few minutes to make sure all members are in here, as it's a request for a recorded vote.

The Chair: Okay. We will recess for five minutes.

Mr Jackson: Actually, according to the standing rules, you're guided.

Mr Hope: According to the standing rules, I'm also entitled to time before a recorded vote.

Mr Jackson: It's 20 minutes automatically. That's all I'm saying.

Mr Hope: Okay, if you want to take 20 minutes, then we're willing to take the 20 minutes.

The Chair: Given the hour, if we are going to recess, we still have a fair amount of work to do. If we are going to be out for 20 minutes under the standing orders, I would suggest that we break for lunch and come back at 1:20, if that's acceptable.

Mr Jim Wilson: I think all parties would agree that we've been moving along in a very cooperative manner with this legislation, far more cooperative, I hedge to say,

in many of these clauses than perhaps the interest groups would like to have seen. To have Mr Perruzza admonish members of the Liberal Party a few minutes ago for not holding their hands up long enough and then for him to leave the room and now for the government not to have enough members here for a vote, I find insulting. We have put a lot of time and effort into this, and we don't need the government playing games with regard to votes.

The Chair: I think your comments are very much in order, that we have been working with dispatch and in a very cooperative mode. I think it is important that we ensure that members are here, because we are going through this legislation in a certain order. We will recess now. We will reconvene at 1:20 because we had agreed that we would break at 12:30 for 1:30. We will break at 12:20 and reconvene at 1:20. We are recessed.

The committee recessed at 1222.

AFTERNOON SITTING

The committee resumed at 1333.

The Chair: We will now reconvene the meeting of the standing committee on social development, clause-by-clause on Bill 101, An Act to amend certain Acts concerning Long Term Care.

Our first order of business will be to conduct the vote on the Conservative amendment to clause 12(s.1). Shall Mr Wilson's motion carry?

Mr Jim Wilson: I request a recorded vote.

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

Navs

Hope, O'Connor, Owens, Perruzza, Wessenger, Wiseman.

The Chair: The motion is defeated.

We then move on to the Conservative motion, clause 12(v.1), Mr Wilson.

Mr Jim Wilson: I move that clause 12(v.1) of the Charitable Institutions Act, as set out in subsection 9(10) of the bill, be struck out and the following substituted:

"(v.1) prescribing, for the purpose of section 9.15, the additional documents that the approved corporation must have available for inspection in the approved charitable home for the aged, and governing the notice required to be posted under that section."

I think it's self-explanatory.

The Chair: Any comments?

Mr Wessenger: We'll be voting against this, because we find it's unnecessary.

The Chair: Shall the motion moved by Mr Wilson carry? All in favour? Opposed? The motion is defeated.

We then move on to the government motion which is next, to 12(x.1).

Mr Wessenger: I move that subsection 9(11) of the bill be amended by adding the following clause to section 12 of the Charitable Institutions Act, after clause (x):

"(x.1) governing inspection reports."

The Chair: Any comment? Shall Mr Wessenger's motion carry? Opposed? Carried.

We then move on to another government motion.

Mr Wessenger: I move that clause 12(z) of the Charitable Institutions Act, as set out in subsection 9(12) of the bill, be struck out and the following substituted:

"(z) governing short-stay programs in approved charitable homes for the aged."

The Chair: Any comment? Shall Mr Wessenger's motion carry? All in favour? Opposed? Carried.

The next, again a government motion.

Mr Wessenger: I move that clause 12(z.2) of the Charitable Institutions Act, as set out in subsection 9(12) of the bill, be struck out and the following substituted:

"(z.2) governing the quality management system to be developed and implemented by approved corporations for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to residents of approved charitable homes for the aged."

The Chair: Comments? Shall Mr Wessenger's motion carry? All in favour? Opposed? Carried.

The next motion is a Conservative—

Mr Jim Wilson: In light of the previous government amendment, I won't be introducing this.

The Chair: The next motion is a government motion.

Mr Wessenger: I move that clause 12(z.3) of the Charitable Institutions Act, as set out in subsection 9(12) of the bill, be amended by striking out "of which notice must be given" in the third and fourth lines and substituting "which must be set out in the notice". Purely technical.

The Chair: Any comment? Shall Mr Wessenger's motion carry? All in favour? Opposed? Carried.

Again, Mr Wessenger.

Mr Jim Wilson: It's a little more than technical, Mr Wessenger.

Mr Wessenger: I move that subsection 9(12) of the bill be amended by adding the following clauses to section 12 of the Charitable Institutions Act, after clause (z.3):

"(z.3.1) respecting the establishment and conduct of residents' councils;

"(z.3.2) respecting the financial and other information and the assistance that an approved corporation must give to a residents' council and a residents' council assistant."

This is a consequence of amendments of section 9.16 regarding residents' councils. This is stood down.

The Chair: This is stood down. We then move to a Liberal amendment

Mrs Sullivan: My amendment is identical to that of the government, so I won't read it in.

The Chair: We now have a replacement from the yellow sheets, 9.1, section 13, a government motion.

1340

Mr Wessenger: I move that the bill be amended by adding the following section after section 9:

"9.1 The act is further amended by adding the following section:

"Transition

"13(1) This section applies until the Substitute Decisions Act, 1992 comes into force, and when the Substitute Decisions Act, 1992 comes into force, this section is repealed.

"Identifying person who is lawfully authorized

"(2) For the purposes of the provisions of this act and the regulations relating to approved charitable homes for the aged, a person mentioned in a paragraph of subsection (3) is lawfully authorized to make a decision on behalf of another person concerning that person's personal care if,

"(a) the person on whose behalf the decision is to be made is apparently incapable of making the decision; and

- "(b) the person mentioned in the paragraph is,
- "(i) at least 16 years old;
- "(ii) available:
- "(iii) apparently capable of making the decision; and
- "(iv) willing to make the decision.
- "Same
- "(3) For the purposes of subsection (2), the following persons may be lawfully authorized:
- "1. The apparently incapable person's committee of the person appointed under the Mental Incompetency Act.
- "2. A spouse or partner of the apparently incapable person.
 - "3. A child of the apparently incapable person.
 - "4. A parent of the apparently incapable person.
- "5. A brother or sister of the apparently incapable person.

"6. Another relative of the apparently incapable person.

"Meaning of 'capable' and 'incapable'

"(4) For the purposes of this section, a person is capable of making a decision if the person is able to understand the information that is relevant to making the decision and is able to appreciate the reasonable foreseeable consequences of a decision or lack of decision, and a person is incapable of making a decision if the person is not capable of making the decision.

"Meaning of 'available'

"(5) For the purpose of this section, a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a decision.

"Meaning of 'spouse'

"(6) In this section, 'spouse' of an apparently incapable person means a person of the opposite sex,

"(a) to whom the apparently incapable person is married; or

"(b) with whom the apparently incapable person is living, or was living immediately before being admitted to the approved charitable home for the aged, in a conjugal relationship outside marriage, if the two persons,

"(i) have cohabited for at least one year,

"(ii) are together the parents of a child, or

"(iii) have together entered into a cohabitation agreement under section 53 of the Family Law Act.

"Meaning of 'partner'

"(7) Two persons are partners for the purpose of this section if they have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

"Ranking

"(8) A person mentioned in a paragraph of subsection (3) is not lawfully authorized to make a decision if a person mentioned in an earlier paragraph of subsection (3) is lawfully authorized to make it.

"Same

"(9) If two or more persons mentioned in the same paragraph of subsection (3) would be lawfully authorized to make the decision, they shall select one person from among them, and the person selected is the only one of them who is lawfully authorized to make the decision.

"Decisions on person's behalf

"(10) A person who makes a decision on behalf of an apparently incapable person shall do so in accordance with the following principles:

"1. If the person knows of a wish that the apparently incapable person expressed while capable, the person shall make the decision in accordance with the wish.

"2. If the person does not know of a wish that the apparently incapable person expressed while capable, the person shall make the decision in the apparently incapable person's best interests.

"Rest interests

"(11) In deciding what an apparently incapable person's best interests are, the person making the decision shall take into consideration.

"(a) the values and beliefs that the person knows the apparently incapable person held when capable and believes the apparently incapable person would still act on if capable; and

"(b) the apparently incapable person's current wishes, if they can be ascertained."

I'm going to make some initial comments and then I'm going to turn it over to legal counsel for explanation.

The Chair: Before you begin your comments, may I note that this is the motion, once we have dealt with it, that will allow us to go back and deal with the various deferred motions. That's just so people are aware. Mr Wessenger.

Mr Wessenger: My initial comments are that this language is based on language and similar to language in the Consent to Treatment Act. It doesn't contain everything in the Consent to Treatment Act, and there are some differences which I will ask counsel to explain rather than my attempting to do so.

The reason it's felt to be necessary is because there is no provision now for any decision-making by a substitute for a person in a home for the aged or a nursing home, and until the Substitute Decisions Act comes into effect, there's a gap. So it was felt that legislation is needed to cover this gap period, or otherwise you're going to have no one able to make a substitute decision on behalf of an "apparently incapable person."

With that, I'll turn it over to counsel. Probably what needs some explanation, for myself and probably for all committee members, is the use of "apparently incapable person."

Ms Czukar: I can explain that. The use of the term "apparently incapable" is because we didn't want to introduce or attempt to introduce in one section the complete scheme for assessing and having to describe how capacity would be assessed and who could assess it and so on. We wanted to introduce some means of identifying a substitute decision-maker, and the language we've used, which is lawfully authorized throughout the sections that have been stood down, is in order to accommodate the Substitute Decisions Act once it does come into force. So this is an interim provision to give some guidance as to who would be authorized to make decisions and on what basis. We can only use the term "apparently incapable" to give some kind of indication that obviously a substitute decision-maker

only comes into play when someone is not able to make the decision himself or herself.

Mrs Sullivan: I can only say that, in my view, the entire approach to substitute consent and determination in this bill has been very badly thought out and that we're faced with an amendment, a motion, that would mimic but would not provide the protections, of the consent to treatment and substitute decisions acts particularly, to people who are residents or potential residents in that there's no appeal with respect to somebody's determination that they are "apparently incapable." You're either capable or you're incapable, and that's when the common law kicks in now and that's when the other laws kick in with respect to a committee or a power of attorney.

What is happening here is that the current law, in every other situation and circumstance with respect to consent, is the law which is being followed until Bill 108 and Bill 109 are proclaimed, except that all of a sudden here, only for those people who are applying or who are residents of long-term care facilities, there is another and different approach to how substitute decision-making will be done on their behalf.

I just think this is an inappropriate way. This bill is going to have to be reopened when Bill 108 and Bill 109 come into force. It certainly will, because the assessment provisions will override this bill.

The other question is that all of a sudden now you have two standards. You have a standard of this bill and then you have a standard that's imposed by Bill 108 and Bill 109 with respect to capacity. Here we have a person who may or may not be, depending on some judgement made by somebody whom we don't know, who may or may not be qualified to make that judgement. "Apparently incapable." I think this is an outrageous approach to substitute decision-making. I think it should be yanked.

Mr Jim Wilson: Actually, I wouldn't mind hearing the explanation again from legal counsel about apparently incapable persons. It does appear to me that we're setting up a whole new type of incapable person, and that indeed worries me. It's bad enough being labelled incapable after you go through the rather stringent tests that are required by the Substitute Decisions Act that we dealt with last year—and it's yet to come into effect—without adding insult to injury and telling someone they're apparently incapable and having sort of a quasi-legal grey area.

The Chair: We'll answer that question and then we'll continue, legal counsel.

Ms Czukar: I don't know what more I can add, other than to say that there are many people, obviously, in charitable homes for the aged, which is what we're using and what we're dealing with now, and in the other long-term care facilities who are clearly incapable of making personal care decisions, and this deals with decisions regarding personal care. That's specified in subsection (2), decisions "on behalf of another person concerning that person's personal care."

There is currently no scheme for determining and there's no way of determining who has legal authority to make substitute decisions on behalf of that person unless they have a committee appointed under the Mental Incompetency Act, which is highly unusual for people right now, and it's not clear that under the Mental Incompetency Act currently, a committee has the capacity to make decisions regarding personal care. They are generally concerned with property decisions.

1350

So it's felt that this kind of provision does at least clarify, when it's clear that a person is not capable of making a decision about admission to a home or receiving certain kinds of services or entering into a contract for additional care or that sort of thing, that at least this section would allow the home or the placement coordinator to clearly identify a person who can make a substitute decision, and it also gives guidance to the substitute decision-maker about how to make a decision on that person's behalf.

I'd also just point out that 13(1) specifies that when the Substitute Decisions Act comes into force, this section is repealed. So it's clearly only a transitional provision until then

Mr Jim Wilson: Mr Chairman, I appreciate the problem the government has gotten itself into and I don't want to see Bill 101 held up because of difficulties with this gap between the Substitute Decisions Act coming into effect and this act coming into effect. However, I just want to point out that what I just heard from legal counsel offends me, and I don't want legal counsel to take it personally, but offends me in the sense that we spent a considerable amount of time as legislators and as a committee learning at first hand that it isn't very clear and that stringent tests are required—the safeguards—and that it's a very serious matter when someone is deemed incapable.

Had legal counsel participated in those hearings when we were dealing with the Substitute Decisions Act, I think that a lot of groups made it very clear that this isn't so cut and dried and that a lot of factors which are included in the Substitute Decisions Act, a lot of safeguards, are there because we learned that you can't just walk in, look at someone for a moment and decide that he is clearly not able to make decisions regarding his personal care. I think that to go into this language of "apparently capable" or "apparently incapable" is in fact insulting and probably sets us back a couple of years in terms of all the work that was done around the Substitute Decisions Act.

Mrs Sullivan: I think one of the reasons I find this amendment and its earlier draft so offensive is that there was no debate with respect to this matter during the hearings. No intention of the government with respect to coming forward with these kinds of provisions was put on the table so that they could be explored.

I would suggest to you, by example, that had there been debate—and unfortunately we have to get into it now, even though we are in clause-by-clause—it would've been obvious to everybody at this table that for a significant number of people who are residents of homes there is no next of kin, by example, who are included in the ranking of substitute decision-makers. There is nobody. In fact, people in the home, the management of the home, are operating as substitute decision-makers.

There is no determination here and no proposal here as to who shall determine. We've heard counsel speak about "clearly incapable." Who is determining that a person is incapable? What factors are being taken into account that are not spelled out here?

We know and certainly any of us who've spent any time at all dealing with long-term care facilities know that with many of the people who are resident in long-term care facilities, the spouse may well have already been assessed as incapable himself or herself. There are problems that are not addressed with this motion, and I think it is going to be extraordinarily problematic if this passes.

Mrs O'Neill: We're talking about persons, and I don't think we should forget that. We're talking about making judgements about persons, persons who have a certain degree of mental capacity, persons who have feelings, emotions, traditions and values, which are very hard to judge. The seriousness of this is that we're being asked to support this, and we haven't got a clue about who would be doing the assessing, and legal counsel has been very specific. Would they be qualified or not qualified? There's no way I can support this, because I really do feel it is more than offensive to me: I think it's unjust.

I think it would be great for the home to know how to deal with this matter, and there is other legislation coming, but people are suggesting this is a transitional mode. The poor people who are going to be in this transition have no safety net; they have absolutely no protection. There's going to be a whole set of rules that will apply for how many months or years, and they're the only ones caught in the trap. I'm sorry, there's no way I can support this. It is, in my mind, very dangerous.

Mr Wessenger: I would just like to shortly respond to the extent that at the present time there's no one who can substitute-decide for an incapable person unless he happens to be named a committee of the person under the Mental Incompetency Act, and the homes themselves have requested that we clarify in the legislation who may give instructions to the homes. Without this, you're basically leaving the situation where the providers themselves will be making the decisions with respect to the care of the individual.

There's also the problem that we have in the act the provision that there be consent to the admission to a home. If we don't have someone as a substitute to consent on behalf of the incapable person, it does create a somewhat difficult administrative situation. I agree that the ideal would be when the Substitute Decisions Act is implemented; there's no question about that.

The Chair: I'll put the question, then. Shall the government motion carry? All those in favour?

Mrs Sullivan: Recorded vote.

The Chair: A recorded vote has been requested. All those in favour of the government motion?

Ayes

Hope, O'Connor, Owens, Perruzza, Wessenger, Wiseman.

Navs

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: The motion is carried. At this point, then, we'll deal with those that have been deferred. Please go back to section 5. I just want to be clear, with the clerk's help, that I've got these in the right order. The first one that I have is the Liberal proposed amendment 9.5(9.1). No? Okay, I'm sorry. I'll just get some help here. While we get the ones that are deferred sorted out for everybody, we'll just have a short recess.

The committee recessed at 1359 and resumed at 1408.

The Chair: The committee can reconvene. What I will attempt to do here is, first of all, just to go in order of the motions that we will need to deal with, most of which have been deferred, but a couple of which are ones we haven't dealt with.

Under section 4 of the bill, we have a Liberal amendment we haven't dealt with to subsection 9(2). That will be the first one we'll deal with. We will then deal, in order, with government amendment 9.3(1)(e)—okay?—then government amendment 9.3(2)(b) and then government amendment 9.3.1. Those are all under section 4.

Then, under section 5, Liberal amendment 9.5(2.2) and Conservative amendment 9.5(5)(a). We will then have a new government amendment—this is again under section 5—to 9.5(8.3.1), then Liberal amendment 9.5(9.1), Liberal amendment 9.5(9.2), government amendment 9.5.1, which is in your yellow sheets, and Liberal amendment 9.5.1.

Mr Wessenger: Then we had one of ours, a new one, 9.5.2. I don't know whether you have that one.

The Chair: Just one second. I'm sorry, government amendment 9.5.2. Okay? Mr Wilson.

Mr Jim Wilson: Could you quickly read off the PC amendment you're expecting, just the number again?

The Chair: Right.

Mr Jim Wilson: There was one mentioned.

The Chair: Clause 9.5(5)(a). It had been stood down. We have then 9.5.1, both a government and a Liberal

We have then 9.5.1, both a government and a Liberal amendment. After that, government amendment, again section 5, 9.12; Liberal amendment, 9.12(2) and (3); Conservative amendment, 9.14(1)(a); government amendment, 9.14; government amendment, 9.16 to 9.20. Then under section 7, Liberal amendment, 10.1(2)(b) and, finally, a government amendment, 12(b.6).

Now we will go back and deal with those and please call upon the Chair to stop and make sure we get this right. The first one we'll deal with then, Ms Sullivan, will be the Liberal amendment, which has been distributed, to section 4 of the bill—

Interjection.

The Chair: I'm sorry, Mr Wessenger, did you-

Mr Wessenger: Could I have an opportunity to identify those motions we'll be supporting? The first one is 9(2).

The Chair: It hasn't been presented yet.

Mr Wessenger: Oh, it hasn't been presented yet; it hasn't been moved. Okay.

The Chair: Ms Sullivan, would you put your motion.

Mrs Sullivan: I move that subsection 9(2) of the Charitable Institutions Act, as set out in section 4 of the bill, be struck out and the following substituted:

"Service agreement

"(2) No payment shall be made under subsection (1) unless.

"(a) the approved corporation receiving the payment is a party to a service agreement with the crown in right of Ontario that relates to the home: and

"(b) the service agreement complies with this act and the regulations."

Mr Chairman, this is a technical amendment to clean up wording in the act to ensure it's the service agreement that complies with the act or the regulation and not the home. It's a wording change.

Mr Wessenger: We'll be voting in favour of this amendment.

The Chair: I'll put the motion then. Shall the Liberal amendment carry? All in favour? Opposed? Carried.

I would then put section 4. No. I can't do that yet. Wait a minute. I'm sorry, I'm ahead of myself. I'm getting excited here. We have a few to deal with.

Government amendment 9.3(1)(e): We have discussed this, so I'm simply going to put them. Shall the government motion carry? All those in favour? Opposed? Carried.

Government motion 9.3(2)(b): Shall the motion carry? Opposed? Carried.

Government motion 9.3.1: Shall the motion—

Mr Wessenger: Would it be possible to withdraw this motion?

The Chair: Anything is possible.

Mr Wessenger: We've already passed-

Mr Jim Wilson: Mr Chairman, I can't find half of these in my file and it would be a little unfair to vote without seeing them again. I'd asked the clerk prior to the recess to perhaps give us copies of these again because they're all over my desk.

The Chair: All right. Let's just take a brief pause and we'll dig those out so we can make sure we have them in front of us. Okay? A two-minute pause.

The committee recessed at 1415 and resumed at 1428.

The Chair: We'll reconvene. The clerk is just distributing a set of the stood-down amendments. If I could just remind people that we have dealt with the Liberal amendment subsection 4.9(2), with the government 9.3(1)(e) and 9.3(2)(b). I called government amendment 9.3.1 and just to confirm, Mr Wessenger, you said?

Mr Wessenger: I had indicated that we wished to withdraw this motion because it's already been covered by existing Liberal motions.

The Chair: Is that clear then? Subsection 9.3(1) is withdrawn. Now that then covers all of the amendments under section 4, so I will put the question: Shall section 4 of the bill, as amended, carry? In favour? Opposed? Carried.

We are now at section 5, the Liberal amendment 9.5(2.2). Ms Sullivan has moved that. Shall that motion carry? All in favour? Opposed? It is defeated.

Then the Conservative motion of Mr Wilson, which was 9.5(5)(a). Shall Mr Wilson's motion carry? All those in favour? Opposed? Defeated.

I need just a bit of guidance here. We passed a government motion, 9.5(5) to (8.6). Ms O'Neill, help me again. What do we call this?

Mrs O'Neill: Gold

The Chair: The gold sheet you have, which is the amendment to section 5 of the bill, subsection 9.5(8.3.1), is a new government amendment. So if I could ask Mr Wessenger to first read it and then explain it.

Mr Wessenger: I move that paragraph 2 of subsection 9.5(8.3.1) of the Charitable Institutions Act, added to section 5 of the bill by the government motion relating to subsections 9.5(5) to (8.6) of the Charitable Institutions Act, be struck out and the following substituted:

"2 An assessment or information relating to the person's requirements for medical treatment, health care or other personal care."

I'll ask counsel to explain the necessity for this one.

Ms Czukar: The reason this one was introduced was that it was pointed out to me by legislative counsel last night, after we had accepted this amendment, which was brought forward by one of the opposition parties, that it did read "medical treatment, health care or personal care." There's a problem with using the term "personal care" here because it's used in the substitute decision-making section where we've said decisions concerning personal care, and we wanted to make it clear that personal care includes medical treatment and health care, so we've said "medical treatment, health care or other personal care" to make it clear that they're all included in personal care and any substitute would make a decision with respect to all of those, which are considered personal care for that purpose. So it's a clarifying amendment suggested by legislative counsel.

The Chair: Any comment? If not, I'll put the motion. Shall the-sorry, Ms Sullivan.

Mrs Sullivan: This amends a very long motion with respect to admission etc; am I correct?

Ms Czukar: That's right.

Mrs Sullivan: You have used in this amendment, then, under (8.3.1) the word "assessment," indicating that it is the placement coordinator who shall make all determinations. So what you are now saying is that for the apparently incapable person, it is the placement coordinator who makes that assessment?

Ms Czukar: No, it doesn't change the substance of it. It's just a clarification of the use of the term "personal care." The amendment that was introduced yesterday in (8.3.1) said medical treatment or health care or personal care.

Mr Wessenger: We've added "other."

Ms Czukar: As a matter of statutory interpretation, it could be taken, because we've used decisions regarding personal care in the substitute decisions section, that if you use that term here it means something different. Legislative counsel might be able to add something to the explanation of the interpretation problem. It's not a change in substance. We don't intend it as a change in substance; we intend it to be inclusive.

The Chair: Perhaps we could ask legislative counsel to comment

Ms Gottheil: What was passed yesterday had originally been numbered 9.5(7.1) and in paragraph 2 there was a reference to "medical treatment, health care or personal care." The only change today is we've said "medical treatment, health care or other personal care," just to show that medical treatment and health care would be a form of personal care, too, and that is consistent with the way we've used the words "personal care" elsewhere in this bill.

Mrs Sullivan: Once again, that was my amendment, I believe.

The Chair: Yes.

Mrs Sullivan: How can the government now amend my motion? Is that correct? Counsel just indicated that this is renumbered from an amendment that was put forward yesterday as 9.5(7.1).

The Chair: Ms Sullivan, what we are amending was a government motion.

Mrs Sullivan: Could we have a reclarification of the number, then, of the government motion which is now renumbered?

The Chair: If I understand correctly, what we have amended here, Ms Sullivan, is that yesterday we passed 9.5(5) to (8.6). That was a government motion. This amendment is to that, so it is a government amendment to a motion they had presented and that was passed yesterday.

Mrs Sullivan: There is no (8.3.1) in the amendment

The Chair: Well, there was. They have changed it.

Mrs Sullivan: No, there isn't.

which was passed yesterday.

The Chair: The Liberal 9.5(7.1) was taken and became (8.3.1) with a change of wording. Mr Wilson has a question, but, Ms Sullivan, is that clear?

Mrs Sullivan: I guess I'll check Hansard.

The Chair: Can I ask legislative counsel, who I think understands that as clearly as anybody—do you want to explain it better than I did?

Ms Gottheil: I think what happened yesterday was that the government created (8.3.1). It changed the wording of the Liberal 9.5(7.1), and (8.3.1) became a subsection of 9.5. So this is an amendment to the government motion.

Mrs Sullivan: I understand now, having had some special counsel from counsel, but the committee never received a copy of that amendment. So that's why I was confused when the numbering was changed of the one which the government adjusted from my motion which was put forward yesterday. We did not receive a copy of that.

The Chair: I think, because we have to be clear on this, I will ask the clerk to get a copy of this so that everybody has it, and we will take a short recess in order to get that.

The committee recessed at 1438 and resumed at 1440.

The Chair: I think we now have a copy. As I look at this and recall the discussion yesterday, this arose out of the discussion around both the government motion 9.5(5) to (8.6) and the Liberal amendment 9.5(7.1). This has been redone and now finds itself within this new section 9.5(8.3.1).

I think we've tracked it down, and if I might then put the question, shall the government motion carry? Carried.

The next deferred motion that was stood down was the Liberal amendment 9.5(9.1). Shall Ms Sullivan's motion carry? All in favour? Opposed? Defeated.

Again, a Liberal-I'm sorry.

Mr Wessenger: Just a minute, Mr Chairman. Maybe we're looking at the wrong motion—the veterans' one I guess should be withdrawn, I think.

Mrs Sullivan: Yes, just hang on so that we can flip forward quickly. This is subsection 9.1?

The Chair: Yes, 9.5(9.1).

Mrs Sullivan: I do not intend to put this motion forward. I guess I've already read it in, so I have to withdraw it.

The Chair: Okay. If I could ask the clerk for guidance. We did not mean to defeat it. Do we have to do anything—I think unanimous consent to undefeat it and to allow Mrs Sullivan to withdraw it? Agreed. Mrs Sullivan, 9.5(9.1) is now withdrawn.

We then go to the next amendment, which is 9.5(9.2). Ms Sullivan, were you going to withdraw that one as well, 9.5(9.2)?

Mrs Sullivan: "Preference for persons discharged from facilities," is that what's at the top of that?

The Chair: Yes

Mrs Sullivan: No. I don't want to withdraw that.

The Chair: Shall Mrs Sullivan's motion carry? All in favour? Opposed? Motion defeated.

We then have a government motion 9.5.1, which I believe is new. I would ask the parliamentary assistant to read that into the record. That is a yellow sheet. Everyone should have it.

Mr Wessenger: I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act, after section 9.5:

"Information to approved corporation

"9.5.1(1) A placement coordinator who authorizes a person's admission to an approved charitable home for the aged shall give to the approved corporation maintaining and operating the home the information mentioned in a paragraph of subsection (2) if,

"(a) the placement coordinator has the information

mentioned in the paragraph; and

"(b) consent to the disclosure of the information to the approved corporation is given by,

"(i) the person whose admission is authorized; or

"(ii) the person, if any, who was lawfully authorized to consent to admission to the approved charitable home for the aged on behalf of the person whose admission is authorized.

"Sam

"(2) The information referred to in subsection (1) is the following:

"1. Information about assessments of the person whose admission is authorized.

"2. Information about the person's medical history.

"3. Information about the person's social and other care requirements.

"4. The name and address of the person, if any, who was lawfully authorized to consent to admission to the approved charitable home for the aged on behalf of the person whose admission is authorized."

The Chair: Commentary, Mr Wessenger?

Mr Wessenger: Perhaps I'll ask counsel to give the reason for this.

Ms Czukar: This was drafted as an alternative to an amendment that was put forward by Mrs Sullivan, I believe, regarding the same topic. This was just worked out with legislative counsel in light of other amendments that have been made and to make it more certain.

Mrs Sullivan: Mr Chairman, we'll support this motion and subsequently withdraw the one which was stood down.

Mr Jim Wilson: I just want to indicate my support for this motion, Mr Chairman. I think it expands the scope of the information that has to be provided to a home from the placement coordinator, and does so in a very commonsense way.

The Chair: Thank you. I'll put the motion. Shall the government motion carry? All in favour? Opposed. Carried.

Ms Sullivan, vou've withdrawn your stood-down motion. That is then withdrawn.

We then have another new motion which is government motion 9.5.2, parliamentary assistant.

Mr Wessenger: I move that section 5 of the bill be amended by adding the following section to the Charitable Institutions Act. after section 9.5.1:

"Preference for veterans

"9.5.2 The minister shall ensure that preference is given to veterans for access to beds that,

"(a) are located in approved charitable homes for the aged for which funding is provided under an agreement between the government of Ontario and the government of Canada relating to veterans; and

"(b) are designated by the minister as veterans' priority access beds."

The Chair: Commentary?

Mr Wessenger: I think we've been struggling for some time to come up with the appropriate language to deal with the issue of the priority access beds in the Perley hospital, and we believe this is the appropriate language.

Mr Jim Wilson: I just want to say that we're pleased to see this amendment come forward. It's been quite a few weeks now, putting pressure on the government so that it would come forward like this. I don't think it's a cure-all, but it's better than what we were offered prior to this, which was simply an exchange of a letter between the provincial Health minister here in Ontario and Kim Campbell, the federal Minister of Defence. I'm certainly pleased to see that the government has seen fit to concede to the request of the Royal Canadian Legion and put in this legislation

some safeguard to ensure that there is a preference of access for veterans.

Mrs O'Neill: I just wanted to verify, does this amendment, which I agree with, guarantee within the existing contract, which we were shown, though I have never received a copy but I had seen it being flashed around this committee, between the feds and provincial governments on this issue, particularly the Perley and the Rideau Veterans, does this act, what should I say, beef up that contract which the veterans found was wanting and did not follow what they considered were the federal regulations?

Mr Wessenger: I think it's fair to say that this amendment reinforces the interpretation given by the minister to the agreement in the sense that it's in line with what we've indicated, that we believe the rights do exist under the agreement. We have now put this into legislation and it reinforces that.

The Chair: Ms O'Neill, just on your other point, a copy of the agreement was sent to all members and you should have received it; if not, I'll make sure that you do.

Mrs O'Neill: I have it and I think it's something I've been looking for, but it's possible that I haven't got it yet.

The Chair: If need be, I'll give you mine.

Mrs O'Neill: I will check with my staff.

Mrs Sullivan: I withdrew the motion that I had put forward with reference to this section in favour of the wording which counsel has developed here. I think that the use of the word "minister" rather than "placement coordinator" having the obligation of ensuring that the contract is met is a significant improvement.

I think this also allows for the Department of Veterans Affairs in Ottawa to become, in fact, the placement coordinator for veterans' beds. As I speak to this, I want to say that there appears to be some confusion in the third party's motion, which talked about the legion guaranteeing these beds, and the contractual relationship is between the Department of Veterans Affairs and the provincial ministry. This reflects that contract and I'm pleased to support it.

The Chair: I'll put the motion then. Shall the government motion carry? All those in favour? Opposed? Carried.

We would then go to government motion 9.12. Shall the motion carry? Opposed? Carried.

Still under section 5, the Liberal amendment, 9.12(2) and (3). Ms Sullivan, was that to be withdrawn?

Mrs Sullivan: I think I'd like to proceed with a vote on this, Mr Chairman, because while the previous motion covers half of what my motion was, it doesn't cover the second half with respect to implementation.

The Chair: I'll put the motion then, and this is, again, 9.12(2) and (3). Shall the motion carry? All in favour? Opposed? Okay, it's defeated.

We then go to Mr Wilson's motion, 9.14(1)(a). Shall Mr Wilson's motion carry? All those in favour? Opposed? Defeated.

Government amendment 9.14: Shall the motion carry? All in favour? Opposed? Carried.

Mrs Sullivan: Could you slow down a second, please, Mr Chairman?

The Chair: Yes, sorry. I will slow down.

Okay, that was 9.14, and I'll just tell you where we're going. The next one will be government motion, 9.16 to 9.21, to be followed by the Liberal motion, 9.16 to 9.20. Those were both stood down. Do you have those to hand?

Mr Wessenger: The residents' council.

The Chair: Okay? are you ready?

Mrs Sullivan: The residents' council, Mr Chairman, yes. I stand that down because it's fundamentally covered by the government motion.

The Chair: Okay, sorry. I'll let you do that. We'll just deal with the government amendment first.

Mr Jim Wilson: Can I ask a question on the government amendment?

The Chair: Yes.

Mr Jim Wilson: I'm interested to know from the parliamentary assistant, as soon as I find the section—it would be on page 3 of the amendment 9.18(c)(ii).

The Chair: Can you just repeat that?

Mr Jim Wilson: Sorry, 9.18(c)(ii), which is on page 3, roman numeral (ii), and it starts off: "Review the allocation of money for accommodation, care, services, programs and goods provided in the home." I would like to know exactly what the word "review" means and what the scope of the intent is.

Mr Wessenger: I'll ask legal counsel.

Ms Czukar: These are the powers of the residents' council, so these are items that the residents' council can do. These are taken from the residents' council powers in the Nursing Homes Act and there's currently a provision which allows residents' councils to review the allocation of money for services provided in the home. We've simply changed the wording here to reflect accommodation, care, services, programs and goods, which we've used throughout the bills, to describe what is to be provided under the service agreement and what payments are to be made for. So the scope of it is that they can review how money is allocated for those things with representatives of the corporation to the same extent it's done with nursing home operators now.

Mr Jim Wilson: I just want to make sure that "review" doesn't in any way give the members of the residents' council the ability to instruct the administration of the home in any way. It's simply a review.

Ms Czukar: I would think "review" in that context would have its ordinary meaning, which would simply mean "review" and not anything more than that.

The Chair: Shall the government's motion carry? Opposed? Carried.

Mrs Sullivan, you will then withdraw your motion?

Mrs Sullivan: Okay.

The Chair: Then we move to Mrs Sullivan's motion, clause 10.1(2)(b).

Mrs Sullivan: Mr Chairman, I believe that is covered now with subsequent government amendments, so I will withdraw that.

The Chair: Okay, that is withdrawn.

Shall section 5, as amended, carry? Carried.

We have dealt with section 6.

Shall section 7 carry? Carried.

I believe we carried section 8, at least we should have.

We are then left with the government amendment, clause 12(b.6). Shall the government motion carry? Opposed? Carried.

I'm buried in paper here. Somewhere I had another

document. Here we are.

Mr Jim Wilson: Mr Chairman, on a point of information: I really don't recall actually voting just a moment ago. Why was clause 12(b.6) struck? I'd like it on the record.

The Chair: It was passed.

Mr.Jim Wilson: It was passed to strike it.

The Chair: No. It had been stood down and we just passed it.

Mr Jim Wilson: But it was passed to strike it.

The Chair: Oh, I'm sorry, it was struck out.

Mr Jim Wilson: Could you explain for the record why it was necessary?

Ms Czukar: Clause 12(b.6) is a regulation-making power giving us the power to make regulations requiring and governing consent by or on behalf of persons. This regulation-making power has now been replaced with the transitional section regarding substitute decision-making. So instead of trying to put rules regarding substantive rights about consent and substitute decision-making in the regulations, which would have been very difficult, we've put it in the act.

The Chair: We have then in section 9 a government motion, clauses 12(z.3.1) and (z.3.2). Shall the government motion carry? Opposed? Carried.

Now, says he carefully, shall section 9 of the bill, as amended, carry? Carried.

Mr Wessenger: Did we do 10?

The Chair: No, we didn't do 10, right?

Mr Wessenger: I don't think so. I don't remember doing it.

The Chair: Shall section 10, as in the bill, carry? Carried.

Where are we?

Mr Wessenger: Section 11. We haven't done that yet.

Interjection: Do we have amendments?

The Chair: Yes, we have amendments. So we have completed the Charitable Institutions Act. I'm going to call a short recess as we organize our approach to the remainder of the bill. I would ask everyone to stay with us. We'll collect our paper and get organized. We'll have a short recess.

The committee recessed at 1501 and resumed at 1513.

The Chair: The committee will reconvene. We are now beginning to deal with part III of the bill, Homes for the Aged and Rest Homes Act. We are dealing with part III,

section 11, and the first two amendments I have are Liberal amendments. Ms Sullivan? I will be extemporaneous for a few minutes as she gets a cup of coffee. However, I will not sing.

Mr Jackson: For which we are eternally grateful.

Mrs Sullivan: Mr Chairman, I'll be withdrawing that motion.

The Chair: Okay. You also had the next one.

Mrs Sullivan: I will proceed with this one.

I move that subsection 11(1) of the bill be amended by adding the following definition to the Homes for the Aged and Rest Homes Act:

"'resident' means a person admitted to and lodged in a home:"

The Chair: Just to note again, we're deferring the votes but we can have the debate.

Mr Wessenger: I was just going to indicate that we'll be supporting this one because this is similar to the motion that—

The Chair: In that case—

Mr Jim Wiseman (Durham West): We can vote on that one.

Mr Wessenger: Yes, we could vote on that one. Why don't we?

The Chair: All right. All in favour? Opposed? Carried. The next is a government motion, Mr Wessenger.

Mr Wessenger: I move that the bill be amended by adding the following section after section 11:

"11.1 The act is amended by adding the following section:

"Fundamental principle

"1.1 (1) The fundamental principle to be applied in the interpretation of this act, the regulations and a service agreement relating to a home is that a home is primarily the home of its residents and, as such, it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others.

"Residents' bill of rights

"(2) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall ensure that the following rights of residents of the home are fully respected and promoted:

"1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from

mental and physical abuse.

"2. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

"3. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

"4. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

"5. Every resident has the right to keep in his or her room and display personal possessions, pictures and furnishings in keeping with safety requirements and rights of other residents of the home.

"6. Every resident has the right,

"i. to be informed of his or her medical condition, treatment and proposed course of treatment,

"ii. to give or refuse consent to treatment, including medication, in accordance with the law and to be informed of the consequences of giving or refusing consent,

"iii. to have the opportunity to participate fully in making any decision and obtaining an independent medical opinion concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a home, and

"iv. to have his or her medical records kept confidential in accordance with the law.

"7. Every resident has the right to receive reactivation and assistance toward independence consistent with his or her requirements.

"8. Every resident who is being considered for restraints has the right to be fully informed about the procedures and the consequences of receiving or refusing them.

"9. Every resident has the right to communicate in confidence, to receive visitors of his or her choice and to consult in private with any person without interference.

"10. Every resident whose death is likely to be imminent has the right to have members of the resident's family present twenty-four hours per day.

"11. Every resident has the right to designate a person to receive information concerning any transfer or emergency hospitalization of the resident and, if a person is so designated, to have that person so informed forthwith.

"12. Every resident has the right to exercise the rights of a citizen and to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the residents' council, staff of the home, government officials or any other person inside or outside the home, without fear of restraint, interference, coercion, discrimination or reprisal.

"13. Every resident has the right to form friendships, to enjoy relationships and to participate in the residents' council

"14. Every resident has the right to meet privately with his or her spouse in a room that assures privacy and, if both spouses are residents in the same home, they have a right to share a room according to their wishes, if an appropriate room is available.

"15. Every resident has a right to pursue social, cultural, religious and other interests, to develop his or her potential and to be given reasonable provisions by the home to accommodate these pursuits.

"16. Every resident has the right to be informed in writing of any law, rule or policy affecting the operation of the home and of the procedures for initiating complaints.

"17. Every resident has the right to manage his or her own financial affairs if the resident is able to do so and, if the resident's financial affairs are managed by the home, to receive a quarterly accounting of any transactions undertaken

on his or her behalf and to be assured that the resident's property is managed solely on the resident's behalf.

"18. Every resident has the right to live in a safe and clean environment

"19. Every resident has the right to be given access to protected areas outside the home in order to enjoy outdoor activity, unless the physical setting makes this impossible.

"Further guide to interpretation

"(3) Without restricting the generality of subsection (1), this act, the regulations and a service agreement relating to a home shall be interpreted so as to advance the objective that the resident's rights set out in subsection (2) be respected.

"Deemed contract

"(4) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall be deemed to have entered into a contract with each resident of the home or joint home, as the case may be, agreeing to respect and promote the rights of the resident set out in subsection (2)."

This is in line with the bill of rights that was passed with respect to charitable homes for the aged.

Mrs Sullivan: We'll be supporting this motion.

1520

The Chair: Mr Jackson, same comment? Given that this would appear to be having the support of everyone, I will put this. Shall the government motion carry? Carried.

I would then ask, the Conservative and Liberal motions will be stood down, is that correct, as per our previous discussion?

Mrs Sullivan: Yes. Since the government accepted our recommendation, we'll not be putting our motion forward.

Mr Jim Wilson: The same, Mr Chairman.

Mr Wessenger: It's withdrawn. It should be indicated, by the way.

The Chair: Yes, withdrawn. I would ask then, shall section 11, as amended, carry? Carried.

We then move on to section 12. The first amendment is, I believe, the Liberal amendment 18(2) and (2.1).

Mrs Sullivan: I think there's a government motion which precedes mine.

The Chair: Yes, I think there were some, if people want to just doublecheck. The motion we're going to deal with right now is the Liberal motion which is in our original book.

Mrs Sullivan: No. I will not be putting that forward.

The Chair: So that is withdrawn.

Mr.Jim Wilson: Which one is that?

The Chair: Subsection 18(2.1) is withdrawn. Mrs Sullivan, you had one as well?

Mrs Sullivan: I move that section 18 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection: "Oualifications

"(2.2) No person or entity may be designated by the minister as a placement coordinator unless the person or entity meets the qualifications prescribed by the regulations."

Mr Wessenger: Maybe we could ask that the vote be deferred on this one.

The Chair: Okay. We'll defer the vote. Are there any comments at this time?

Mrs Sullivan: The debate here would be as it was in the previous bill.

Mr Jim Wilson: I thought the government, in the regulations section of the previous bill, attempted to deal with this point. Am I correct?

Mr Wessenger: What we've put in the regulations—we gave the power to make regulations with respect to the qualifications and requirements of the operation of the placement coordination. So yes, we gave the permissive power to bring that in.

The Chair: The next motion is the Conservative motion. Mr Wilson.

Mr Jim Wilson: Before I introduce this, not having had time to thoroughly review the government's pre-drafting of amendments for this bill, I would ask the parliamentary assistant if the wording we dealt with on this point in the previous bill has been incorporated into the government's amendment. Remember we were talking about—

Mr Wessenger: I think I'll ask counsel to clarify.

The Chair: Just to make sure we're all again with the same—this is the new vellow sheet.

Mr Jim Wilson: Perhaps I'll read it in, Mr Chairman.

The Chair: You're going to read it in? Mr.Jim Wilson: If you don't mind.

The Chair: Yes. No.

Mr Jim Wilson: I move that clause 18(5)(a) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"(a) within the six months preceding admission, a placement coordinator has determined that the person is eligible for admission to a home; and"

The Chair: That is your amendment. Mr Parliamentary Assistant, if you would then—

Mr Wessenger: I'll ask counsel to confirm how it's included in the—

Interjections.

Mr Wessenger: We haven't moved ours yet.

Mr Jim Wilson: Oh. How about for information right now.

Mr Wessenger: For information, yes.

Mr Jim Wilson: Just refer me to it perhaps.

Ms Czukar: There's an amended government motion, and in subsection (8.4) it includes the notion of within the six months preceding authorization, which was the wording we had agreed on yesterday when the amended motion was read in.

Mr Jim Wilson: With that on the record, Mr Chairman, I'll withdraw my motion.

The Chair: Okay. Mr Wilson, I must say, has not moved—

Mr.Jim Wilson: No. I moved it.

The Chair: I'm sorry, you moved it and withdrew it. Is that—

Mr.Jim Wilson: Yes.

The Chair: All right, you moved it and withdrew it. Perhaps, Mr Wilson, do you want to put your amendment to 18(6) and then I'll go to the government to deal with its, which is 18(5) to (8.6).

Mr Jim Wilson: I move that subsection 18(6) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Where admission required

"(6) The committee of management or the board of management, as the case may be, of a home shall admit a person who meets the requirements of subsection (5), unless,

"(a) the person requires ventilation therapy or deep bronchial suctioning:

"(b) the person requires onsite surgery;

"(c) the person requires epidural anaesthesia;

"(d) the home is unable to meet the person's care requirements; or

"(e) a ground for refusal of admission prescribed by the regulations exists."

When I introduced a very similar amendment to the Charitable Institutions Act, the parliamentary assistant responded that if any of the conditions (a) through (d) existed, the person wouldn't be eligible for residency anyway. Subsequent to that, the government did make some amendment to its own amendments, and I would be prepared once again to hear the government's argument against my motion.

Mr Wessenger: If I remember correctly, items (a) to (c) in the motion put by Mr Wilson are areas where the person would not be eligible for admission to the facility.

Mr Jim Wilson: Can I just interrupt? How am I sure of that? Operators still tell me that, while that's fine for you to say that—point me to something that assures me that these homes aren't going to be required to provide this type of medical intervention.

Mr Wessenger: It will be included in the eligibility provisions in the regulations.

Mr Jim Wilson: So it will be.

Mr Wessenger: Yes.

Mr Jim Wilson: So I'm not totally out of my mind to suggest that perhaps this amendment is a good safeguard to have in there?

Mr Wessenger: I have assurance from ministry staff that it will be included in the manual.

Mr Jim Wilson: Well, I'll be carrying around my Hansard for quite a few months yet.

The Chair: We'll defer the vote on that. We'll come back to that in terms of the vote, but we would then move to the government amendment 18(5) to (8.6).

Mr Wessenger: Or is it (8.7)?

The Chair: Sorry, it's now (8.7), if I can make that change, and to help as we go along here, people perhaps could just pull the ones that we have deferred. There are two that have been deferred. This is the second one.

1530

Mr Wessenger: I move that subsections 18(5) to (8) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Admission

"(5) The committee of management or the board of management, as the case may be, of a home shall not admit a person unless the person's admission to the home is authorized by the placement coordinator designated for the home under subsection (3), and shall admit a person whose admission to the home is so authorized.

"Applications to placement coordinator

"(6) A person may apply for a determination by a placement coordinator respecting the person's eligibility for admission to a home and for authorization of admission with respect to such home or homes as the person selects.

"Assistance

"(7) A placement coordinator who determines that a person is eligible for admission shall, if the person wishes, assist the person in selecting the home or homes with respect to which the person will apply for authorization of admission.

"Person's preferences

"(8) In assisting a person under subsection (7), the placement coordinator shall consider the person's preferences relating to admission, based on ethnic, spiritual, linguistic, familial and cultural factors.

"Determination respecting eligibility

"(8.1) A placement coordinator shall determine whether a person is eligible for admission to a home only if the person applies for the determination in accordance with the regulations.

"Determination respecting authorization

"(8.2) The placement coordinator designated for a home under subsection (3) shall determine whether to authorize a person's admission to the home only if the person applies for authorization of admission with respect to the home in accordance with the regulations.

"Compliance with act and regulations

"(8.3) A placement coordinator shall make all determinations respecting eligibility for admission and all determinations respecting authorization of admission in accordance with this act and the regulations.

"Assessments, etc. to be taken into account

"(8.3.1) In making a determination respecting a person's eligibility for admission, a placement coordinator shall take into account any of the following which are provided to the placement coordinator:

"1. An assessment of the person made by a health practitioner relating to the person's impairment or capacity.

"2. An assessment or information relating to the person's requirements for medical treatment, health care or other personal care.

"Conditions of authorization

"(8.4) The placement coordinator designated for a home under subsection (3) may authorize the admission of a person to the home only if,

"(a) the placement coordinator or another placement coordinator has determined, within six months preceding authorization, that the person is eligible for admission to a home:

"(b) the committee of management or the board of management, as the case may be, of the home to which the person's admission is to be authorized approves the person's admission to the home; and

"(c) the person consents to being admitted to the home.

"Approval

"(8.5) The committee of management or the board of management, as the case may be, of a home shall approve a person's admission to a home unless,

"(a) the home lacks the physical facilities necessary to

meet the person's care requirements;

"(b) the staff of the home lack the nursing expertise necessary to meet the person's care requirements; or

"(c) circumstances exist which are prescribed by the regulations as being a ground for withholding approval.

"Written notice

"(8.6) A committee of management or a board of management, as the case may be, that withholds approval for the admission of a person to a home shall give to the person, the director and the placement coordinator designated for the home under subsection (3), a written notice setting out the ground or grounds on which the committee or board, as the case may be, is withholding approval and a detailed explanation of the supporting facts.

"Alternative services

"(8.7) A placement coordinator shall suggest alternative services or make appropriate referrals on behalf of an applicant if,

"(a) the placement coordinator determines that the applicant is not eligible for admission to a home; or

"(b) the placement coordinator determines that the applicant is eligible for admission to a home but does not authorize their immediate admission."

I might comment that this is in accordance with all the amendments that were made to the original provisions under the Charitable Institutions Act.

The Chair: Any commentary on that? Ms Sullivan.

Mrs Sullivan: Mr Chairman, I note that the amendments which created some confusion in the previous section of the bill we are considering have all been taken into account in one place, and we'll be supporting this motion.

The Chair: Mr Wilson, I just wanted to give you the opportunity to comment.

Mr Jim Wilson: Essentially, we'll be supporting this motion. I guess it's like being partially pregnant; you either have to support it or not. But we'll be supporting it, given that I think the government has incorporated a number of thoughts we had, including the next PC amendment, I note,

regarding assessments; "taking into account" incorporates the PC amendment. It's not our preferred option, but I think it's the best we're going to do.

The Chair: With that note of agreement, would members like me to put this motion? Shall the government motion carry? All in favour? Carried.

We will then have the Liberal motion.

Mrs Sullivan: We don't need to proceed with that, so I won't put it.

The Chair: Okay. Then I think what I say is that it is not moved. Ms Sullivan, you have two following, subsections 18(6) and 18(7)?

Mrs Sullivan: I don't want to proceed with 18(6) ither.

The Chair: Okay, then we'll deal with subsection 18(7).

Mrs Sullivan: I move that subsection 18(7) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Determination regarding eligibility

"(7) A placement coordinator to whom application has been made in accordance with the regulations for a determination respecting a person's eligibility for admission to a home shall, in accordance with the regulations, determine whether the person is eligible for admission and, if the placement coordinator determines that the person is eligible, determine a priority level for the person's admission."

Mr Wessenger: We ask that the vote be deferred on that.

The Chair: So we will defer the vote on subsection 18(7).

We would then go to the Conservative motion, subsection 18(7.1).

Mr Jim Wilson: I won't be introducing that motion, given that the government's previous amendment incorporated it somewhat.

The Chair: All right, that is not moved. Then we'll return to Ms Sullivan, subsection 18(7.1).

Mrs Sullivan: The government has incorporated this amendment into its motion. It would ensure that assessments of the person's impairment or capacity and his requirements for medical health care and for personal care are taken into account in his placement. We supported the government's amendment, so I will not be putting this one forward.

The Chair: Okay, this is not moved. Then the Conservative motion, subsection 18(8).

Mr Jim Wilson: I move that subsection 18(8) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Priority and authorization

"(8) Subject to subsection (10), if the placement coordinator designated for a home under subsection (3) receives an application, made in accordance with the regulations, for authorization of a person's admission to the home, the placement coordinator shall assign to the person a priority

rating and, taking the priority rating into account, shall determine in accordance with the regulations whether to authorize the person's admission to the home.

"Assigning priority rating

"(8.1) The priority rating assigned to a person under subsection (8) shall be based on the immediacy of the need for admission of the other persons applying for admission.

"Priority rating for spouse

"(8.2) Despite subsection (8.1), a person applying for admission to a home in which his or her spouse is resident shall be assigned, for the purposes of admission to the home, a priority rating that is higher than the priority rating assigned to the applicants for admission to the home who do not have spouses resident in the home.

"Priority rating for veteran

"(8.3) Despite subsections (8.1) and (8.2), a veteran applying for admission to a home that receives or has received financial contributions from the Royal Canadian Legion shall be assigned, for the purposes of admission to such homes, a priority rating that is higher than the priority rating assigned to non-veterans applying for admission to such homes."

1540

Again, this motion is an attempt to set up a priority rating system. It is my understanding that the operating manual that accompanies this legislation has a priority rating system in terms of emergency, non-emergency and others. For the life of me, I don't understand why the government would not want in some way to incorporate that priority rating system and the suggested PC priority rating system into legislation.

Mr Wessenger: I'll ask that the vote be deferred on this one.

The Chair: Okay, the subsection 18(8) vote is deferred.

We then have two Liberal motions, said the Chair—we welcome Mrs Sullivan to her chair—subsections 18(8.1) and 18(8.2).

Mrs Sullivan: The first motion is with respect to taking into account the person's preference and requirements, and the second would ensure that the home could provide the care and services required for the person. As both of those have been incorporated into a government motion at our request, we will not be putting them forward.

The Chair: So subsections 18(8.1) and 18(8.2) are not moved. We will then move to the Conservative motion, subsection 18(8.4); Mr Wilson.

Mr Jim Wilson: I move that section 18 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection after subsection (8.3):

"Alternative plan of care

"(8.4) A placement coordinator shall suggest an alternative plan of care to an applicant if,

"(a) the placement coordinator determines that the applicant is not eligible for admission to the home; or

"(b) the placement coordinator determines that the applicant is eligible for admission to a home but does not authorize their immediate admission."

My comments here would be similar to those made when a similar amendment was put forward under the Charitable Institutions Act. I believe that as a result of this amendment in the first round, there were some changes to the government's own amendments. Perhaps the parliamentary assistant could elaborate on that.

Mr Wessenger: With respect to the Charitable Institutions Act, I believe we had our own amendment. I don't know whether counsel can remember where the amendment is.

Mr Jim Wilson: While counsel is looking, the last PC amendment dealt with the priority rating system regarding veterans and spouses. One of the great benefits of the opposition putting forward those amendments, particularly that one, is that it ensured that the government dealt with the issue of spouses and veterans. We saw today a significant shift in the government. Perhaps the parliamentary assistant can instruct his counsel to look ahead when they can foresee I'm going to ask where changes were made and are contemplated to be made. It might speed up the process a bit if they could second-guess where I'm going, because they know what I'm going to do.

Mr Wessenger: Mr Wilson, your amendment was incorporated in what we've already passed in subsection (8.7).

Mr Jim Wilson: In that case, I'll withdraw my amendment.

The Chair: So subsection 18(8.4) is withdrawn.

Mr Jim Wilson: The point is, we have to move a lot of these so we can get on the record what happened to them in terms of the government accepting the ideas therein. Maybe it would move a little smoother if the parliamentary assistant were to comment as we went along.

The Chair: Thank you. The next motion then is the Liberal 18(9.1). Ms Sullivan.

Mrs Sullivan: Mr Chairman, this motion relates to preference for veterans in veterans' homes, for which there's an agreement between the government of Ontario and the government of Canada. I will not be putting it forward, as the government acceded to our request in the last section of this bill and will do so in this section and will guarantee that those spaces are provided for veterans.

The Chair: And so-

Mrs Sullivan: So I'm not putting this motion forward.

The Chair: Thank you. I'm going to just call a brief recess and ask the critics to gather together quickly, if I can find my club. We'll stand recessed for four minutes.

The committee recessed at 1546 and resumed at 1555.

The Chair: We will continue with our deliberations, and I would just note that the committee will be meeting at 9:30 tomorrow morning to complete its deliberations.

We are at the Liberal amendment, Ms Sullivan, 18(9.2).

Mrs Sullivan: I move that section 18 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection:

"Preference for persons discharged from facilities

"In making determinations under this section, placement coordinators shall, subject to subsection (9.1)"—I think I left out (9.2).

The Chair: It's (9.2) that you're moving?

Mrs Sullivan: Subsection 18(9.2)?

The Chair: Yes. You had not moved 18(9.1), so the next one was 18(9.2), "Preference for persons discharged from facilities."

Did you move veterans?

Mrs Sullivan: The veterans one I just spoke to.

The Chair: Yes, and that was not moved, you said, vesterday.

Mrs Sullivan: I was not moving that one. I just spoke to that.

The Chair: Right. Now I'm asking you about your next one, which is 18(9.2), which deals with preference for persons discharged from facilities.

Mrs Sullivan: Do you have a copy?

The Chair: Yes.

Mr Wessenger: I couldn't find mine either.

The Chair: The Chair always likes to feel useful.

Mrs Sullivan: That is the one that I was reading.

I move that section 18 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection:

"Preference for persons discharged from facilities

"(9.2) In making determinations under this section, placement coordinators shall, subject to subsection (9.1), ensure that preference is given to persons whose discharge as a resident was authorized under section 19.1.2, section 9.7.2 of the Charitable Institutions Act or section 20.3.2 of the Nursing Homes Act."

Mr Wessenger: We will not be voting for this motion.

The Chair: We'll defer-

Mr Wessenger: We'll defer, yes.

The Chair: Ms Sullivan, the next one is yours as well.

Mrs Sullivan: I don't have one here.

Mr Jim Wilson: There's a government one first.

The Chair: Is it for 18.1? Yellow page.

Mr Jim Wilson: I thought there was a government 18(5).

The Chair: There's first of all a government 18.1.

Mrs O'Neill: He means 18(5).

Mr Jim Wilson: Bracket (5) to (8.6).

The Chair: That was dealt with. I believe our next one then is the government 18.1. I stand to be corrected. That is in the yellow pages, which I know means something different in another context, but before this committee it means these yellow pages.

Mr Wessenger: I move that section 12 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 18:

"Information to be given

"18.1(1) A placement coordinator who authorizes a person's admission to a home or joint home, as the case may be, shall give to the municipality maintaining and operating the home, to the municipalities maintaining and operating the joint home or to the board of management of the home, as the case may be, the information mentioned in a paragraph of subsection (2), if,

"(a) the placement coordinator has the information

mentioned in the paragraph; and

"(b) consent to the disclosure of the information to the municipality, the municipalities or the board of management, as the case may be, is given by:

"(i) the person whose admission is authorized; or

"(ii) the person, if any, who was lawfully authorized to consent to admission to the home or joint home, as the case may be, on behalf of the person whose admission is authorized.

"Same

"(2) The information referred to in subsection (1) is the following:

"1. Information about assessments of the person whose admission is authorized.

"2. Information about the person's medical history.

"3. Information about the person's social and other care requirements.

"4. The name and address of the person, if any, who was lawfully authorized to consent to admission to the home or the joint home, as the case may be, on behalf of the person whose admission is authorized."

Should we not stand this one down?

The Chair: Could we have a brief recess?

Mr Wessenger: Could I stand this down before the brief recess?

The Chair: Okay. We'll stand that down then. Just a brief recess.

The committee recessed at 1601 and resumed at 1602.

The Chair: So we are standing down section 12 of the bill, section 18.1 of the government amendment; correct?

Mr Wessenger: Yes.

Mrs Sullivan: Standing down or deferring the vote?

Mr Wessenger: It's being stood down because again this relates to the substitute decisions provisions, which we need to pass before we can deal with this.

The Chair: That also applies to this bill, so we need to pass it. Mrs O'Neill.

Mrs O'Neill: On another point of clarification, and I'm sorry we've all been going in and out making calls about tomorrow—Mrs Sullivan, just before we had a break, said that she would withdraw her section on the veterans because it had been read in. Can I presume that all of those things are going to be transferred from the Charitable Homes Act into these other acts? I just want to be very sure of that, particularly that particular one on veterans' prioritization.

The Chair: The motions that we pass have to be read into the record.

Mrs O'Neill: So the veterans' one will be reread into this act. Is that—

Ms Czukar: Not into this one but into the other.

Mrs O'Neill: Into the Nursing Homes Act?

The Chair: Right.

Mrs O'Neill: Okay. I just wanted to be sure.

The Chair: We will be, if you like, duplicating or replicating in each case. Ms Sullivan.

Mrs Sullivan: I would prefer if a vote were taken on this motion. Even if the section, which comes later, with respect to substitute decisions transitions does not pass—maybe a surprise—but if it does not pass, this amendment is still an important amendment and should also be included as part of the act. I would prefer that the vote proceed on this. We'll be supporting this.

The Chair: Parliamentary assistant?

Mr Wessenger: Perhaps let legal counsel give some explanation here about it.

Ms Czukar: The reason for standing it down is that there's reference to the person who is lawfully authorized to consent to admission. If the substitute decisions section for some reason didn't pass in this act, then that wouldn't have any meaning. It wouldn't be clear who was lawfully authorized to consent to the admission.

The Chair: I have Ms Sullivan and Mr Wilson.

Mr Jim Wilson: Mr Wilson and then Ms Sullivan.

The Chair: Okay. I just thought—why don't we just follow up on that and then we'll go to you.

Mrs Sullivan: In fact, this section would still stand and have the full force as a result of common law and as a result of existing other provisions for committee or power of attorney or common law. There are provisions, and the concepts that are included in this section are important to be maintained in the bill whether or not the substitute decisions sections proceed.

The Chair: The parliamentary assistant has a suggestion, and then I'll go to Mr Wilson.

Mr Wessenger: I have a suggestion that would solve a lot of this problem of standing down; that is, that with the unanimous consent of the committee we could move the motion on substitute decisions and pass it. Then we won't have all this problem of standing down. I would ask for unanimous consent.

The Chair: Is that agreeable? Agreed? Ms Sullivan?

Mrs Sullivan: I suppose we might as well. I don't like that section, but I like this one. That's fine.

The Chair: Okay. We will then move to the government motion, if we just get it here.

Mr Wessenger: It's section 18.1, section 32 of the Homes for the Aged and Rest Homes Act.

I move that the bill be amended by adding the following section after section 18:

"18.1 The act is further amended by adding the following section:

"Transition

"32(1) This section applies until the Substitute Decisions Act, 1992 comes into force, and when the Substitute Decisions Act, 1992 comes into force, this section is repealed.

"Identifying person who is lawfully authorized

"(2) For the purposes of this act and the regulations, a person mentioned in a paragraph of subsection (3) is lawfully authorized to make a decision on behalf of another person concerning that person's personal care if,

"(a) the person on whose behalf the decision is to be made is apparently incapable of making the decision, and

"(b) the person mentioned in the paragraph is,

"(i) at least sixteen years old;

"(ii) available;

"(iii) apparently capable of making the decision; and

"(iv) willing to make the decision.

"Same

"(3) For the purpose of subsection (2), the following persons may be lawfully authorized:

"1. The apparently incapable person's committee of the person appointed under the Mental Incompetency Act.

"2. A spouse or partner of the apparently incapable erson.

"3. A child of the apparently incapable person.

"4. A parent of the apparently incapable person.

"5. A brother or sister of the apparently incapable person.

"6. Another relative of the apparently incapable person.

"Meaning of 'capable' and 'incapable'

"(4) For the purpose of this section, a person is capable of making a decision if the person is able to understand the information that is relevant to making the decision and is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision, and a person is incapable of making a decision if the person is not capable of making the decision.

"Meaning of 'available'

"(5) For the purpose of this section, a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a decision.

"Meaning of 'spouse'

"(6) In this section, 'spouse' of an apparently incapable person means a person of the opposite sex,

"(a) to whom the apparently incapable person is married; or

"(b) with whom the apparently incapable person is living, or was living immediately before being admitted to the home, in a conjugal relationship outside marriage, if the two persons.

"(i) have cohabited for at least one year,

"(ii) are together the parents of a child, or

"(iii) have together entered into a cohabitation agreement under section 53 of the Family Law Act.

"Meaning of 'partner'

"(7) Two persons are partners for the purpose of this section if they have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

"Ranking

"(8) A person mentioned in a paragraph of subsection (3) is not lawfully authorized to make a decision if a person mentioned in an earlier paragraph of subsection (3) is lawfully authorized to make it.

"Same

"(9) If two or more persons mentioned in the same paragraph of subsection (3) would be lawfully authorized to make the decision, they shall select one person from among them, and the person selected is the only one of them who is lawfully authorized to make the decision.

"Decisions on person's behalf

"(10) A person who makes a decision on behalf of an apparently incapable person shall do so in accordance with the following principles:

"1. If the person knows of a wish that the apparently incapable person expressed while capable, the person shall make the decision in accordance with the wish.

"2. If the person does not know of a wish that the apparently incapable person expressed while capable, the person shall make the decision in the apparently incapable person's best interests.

"Best interests

"(11) In deciding what an apparently incapable person's best interests are, the person making the decision shall take into consideration.

"(a) the values and beliefs that the person knows the apparently incapable person held when capable and believes the apparently incapable person would still act on if capable; and

"(b) the apparently incapable person's current wishes, if they can be ascertained."

The Chair: I understand that this is exactly the same wording as was in the previous similar amendment to the Charitable Institutions Act?

Mr Wessenger: Yes, it is.

The Chair: Okay, comments: Ms O'Neill and Mr Wilson.

Mrs O'Neill: I have a couple of questions, Mr Chairman. Will the bill have to be opened again once this transition period is over?

1610

Mr Wessenger: No, it will not have to be opened again; it will automatically be repealed when the Substitute Decisions Act is proclaimed.

Mrs O'Neill: This section of the bill will be repealed.

Mr Wessenger: Yes, automatically.

Mrs O'Neill: Okay. My second question is this: You, as parliamentary assistant, stated earlier today that this was a request of the homes. Can I then take it that this is a political decision to do it this way?

Mr Wessenger: No, it is not. It was felt to be in the best interests of all concerned that there be a substitute decision-maker in the case of incapable persons rather than to leave the situation existing where the provider would be the sole decision-maker with respect to the treatment, and it also is to cover the technical problem of admission of an incapable person to a home.

Mrs O'Neill: I tend to disagree that it's not political, because we certainly haven't got unanimity on this issue here and what the best interests of all concerned are is certainly up for interpretation.

Has it anything to do with liability and the homes not being willing to continue in their position?

Mr Wessenger: I don't think so, no. I would not say that at all. It's really based on the question of trying to ensure that the family has the input with respect to the decision

Mrs O'Neill: As we've been told this morning, the next of kin is often a non-existent entity. I still feel this is very dangerous, and I am certainly not going to support it in any part of any of these bills.

Mr Jim Wilson: I too have a great many problems with this. I want to ask, who determines capacity and who does the assessment? I think it's important we have at least that clear if this is to be transitional legislation.

Mr Wessenger: I will ask legal counsel to respond to that one

Ms Czukar: Because the terminology is "apparently incapable," incapable has a definition. It would be, as it is now, up to the party responsible for obtaining a consent or having someone sign a contract to satisfy themselves whether the person has capacity to do either of those things. So it would be that person who would decide, as they do now, whether they're going to accept the person's consent or look for a substitute consent because they don't think the person is capable of giving a valid consent. That's the way it is now.

What this section does is give them some guidelines about what capacity means and who would make the substitute decision if they are not prepared to accept the consent from the individual himself or herself.

Mr Jim Wilson: I can see the problem. In one of the homes in my riding, there are many young people who, I would think, are and have in the past been deemed incapable, and their families either aren't available to make health care decisions or have really abrogated that responsibility to the administrator of the home. What happens then? Will the administrator continue to be the substitute decision-maker in conjunction with the—what do we call the state body?—public trustee's office?

Ms Czukar: That's essentially what would happen. It would be the status quo now, which is that if there is no next of kin willing to undertake that decision-making responsibility or who's not available within range to make the decision, then service providers or placement coordinators or whoever have to accept a decision by the person—do whatever they do now.

Sometimes they just proceed without someone's consent if there's absolutely no one to do it; sometimes they don't. Sometimes what they do is restrict the person's freedom instead and decide not to allow the person to do certain things, because they don't feel they've got a valid consent.

Mr Jim Wilson: I just don't understand it. I agree with Mrs O'Neill. It seems to me it is somewhat of a political decision, given that you've decided to go ahead with some sort of half-baked substitute decision system. It certainly doesn't go as far as the Substitute Decisions Act, and we

were told how dangerous it could be if we didn't get that act right, so we spent a long time trying to get it right.

I think you've done this to save face, because you've got one act that's in the can that isn't yet in effect, you've got this one coming on stream, and you want to say that at least it was an attempt to conform to the Substitute Decisions Act. I don't like it. I think you're creating more problems than it's worth.

The Chair: I'll put the motion. Mrs O'Neill: A recorded vote.

The Chair: A recorded vote. Shall the government motion, section 18.1, carry? All those in favour?

Aves

Hope, Jamison, O'Connor, Owens, Wessenger, Wiseman.

The Chair: All those opposed?

Navs

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: The motion is carried. Having done that, we will go back—could I have the attention of Mr Hope? There were several votes that were deferred earlier. I'd like to deal with them, as well as with the ones that were deferred. I'm going to put them now, if that's agreeable.

Ms Sullivan, the first deferred one was the Liberal amendment 18(2.2). Shall that motion now carry? All those in favour? Opposed? The motion is defeated.

The Conservative motion 18(6): Shall the motion carry? Those in favour? Opposed? Defeated.

Liberal amendment 18(7): Shall the motion carry? All those in favour? Opposed? Defeated.

Conservative amendment 18(8): Shall the motion carry? All those in favour? Opposed? Defeated.

carry? All those in favour? Opposed? Defeated.

Liberal motion 18(9.2): Shall the motion carry? All those in favour? Opposed? Defeated.

That brings us to 18.1. Shall the government motion 18.1 carry? All those in favour? Opposed? Carried.

We are then at government motion 19.1, am I correct? No. I'm not correct. There was a Liberal motion 18.1 I had overlooked. Mrs Sullivan, we have just passed government motion 18.1, but you have a motion dealing with 18.1.

Mrs Sullivan: This motion related to information which is to be provided to the home via the placement coordinator with respect to the social, personal, medical needs, substitute decision-maker, medical history, information and so on. All of that information is required now by the government motion that we just passed, and therefore I won't be putting it forward.

1620

The Chair: It is not moved. We then come to the government motion, section 19.

Mr Wessenger: I move that section 19 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by:

(i) striking out "a placement coordinator or a member" in the second and third lines and substituting "an"; and

(ii) adding the following subsection:

"Placement coordinator's liability

"(2) Subsection (1) does not relieve a placement coordinator of liability for the acts or omissions of its employees or agents."

Again, this is to ensure that placement coordinators are held accountable for negligence.

The Chair: It's similar to the previous amendment. Γ Il put the motion.

All those in favour of the government motion? Opposed? Carried.

Liberal motion 19.0.1, Ms Sullivan.

Mrs Sullivan: I would just like to clarify with counsel: Has the government motion with respect to the right of appeal of the home or municipality with respect to admission come forward yet?

The Chair: No. That's next, Lunderstand, on 19.1.

Mrs Sullivan: All right. Thank you.

I move that section 12 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 19:

"Notice of determination to municipality, etc.

"19.0.1(1) A placement coordinator who determines that a person's admission to a home or joint home should be authorized shall serve a notice of the determination on the municipality maintaining and operating the home, the municipalities maintaining and operating the joint home, or the board of management of the home.

"Applicable provisions

"(2) Subsections 19.1(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (1).

"Hearing by Appeal Board

"(3) A municipality, the municipalities, or a board of management that is served with the notice of determination is entitled to a hearing by the appeal board if the municipality, the municipalities or the board of management mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(4) Subsections 19.2(1), (2), (3) and (5) apply, with necessary modifications, with respect to a hearing required by a municipality, the municipalities or the board of management under subsection (3).

"Powers of Appeal Board

"(5) After a hearing by the appeal board, the appeal board may.

"(a) affirm the determination made by the placement coordinator;

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator not to authorize the person's admission to the home or joint home." The Chair: Thank you. Comments?

Mrs Sullivan: This motion is put to ensure that if the home is not able to meet the needs of the resident who has been authorized for admission to the home, the home has a right of appeal and a review of the admission requirements.

Mr Jim Wilson: I think it's an important amendment. I want to make it clear in my own mind that the appeal board referred to is the Health Services Appeal Board. Is that correct, Mrs Sullivan?

Mrs Sullivan: That's the only board that's now contemplated in the bill.

Mr Jim Wilson: You didn't move forward with your long-term care report.

Mrs Sullivan: No. They wouldn't accept it.

The Chair: Parliamentary assistant.

Mr Wessenger: We'll be voting against this amendment.

The Chair: I put the motion, then. Ms Sullivan's motion: All those in favour? Opposed? Defeated.

The next motion is government motion 19.1.

Mr Wessenger: I move that section 19.1 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Notice of determination

"19.1(1) If a placement coordinator determines that an applicant for a determination respecting eligibility for admission to a home is not eligible, the placement coordinator shall ensure that the applicant and the person, if any, who applied for the determination on behalf of the applicant are notified of,

"(a) the determination of ineligibility;

"(b) the reasons for the determination; and

"(c) the applicant's right to apply to the appeal board for a review of determination.

"Application to appeal board

(2) The applicant may apply to the appeal board for a review of the determination of ineligibility made by the placement coordinator."

Mr Jim Wilson: We will be supporting this amendment. I believe it is of benefit to consumers.

Mrs Sullivan: This motion in fact incorporates much of what was in the motion which I just placed and the government refused and I would be supporting it.

The Chair: Shall the government motion carry? All those in favour? Opposed? Carried.

Conservative proposed amendment 19.1?

Mr Jim Wilson: Mr Chairman, I'm going to go ahead and introduce this, because it does contain one important element that's not contained in the government's.

I move that subsection 19.1(1) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Notice of determination

"19.1(1) A placement coordinator shall serve a notice on an applicant if the placement coordinator,

"(a) determines that an applicant is not eligible for admission to a home; or

"(b) determines a priority rating for the applicant but does not authorize the applicant's admission to a home."

And I further move that section 19.1 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by,

(a) striking out "determination of ineligibility" wherever it appears and substituting in each place "determination": and

"(b) striking out "for admission to a home" in the first line of subsection (5).

I think it's important that in order to make the system accountable, consumers must be notified of their standing once determination is made by a placement coordinator. I refer members to 19.1(1)(b), which talks about a priority rating. We know the accompanying manual does do some priority rating. That's my understanding of it, and I think consumers should be aware. Even if an authorization for admission doesn't occur, at least they should know where they stood.

The Chair: I'll put the motion. Shall Mr Wilson's motion carry? All those in favour? Opposed? The motion is defeated.

Mr Wilson, you have a subsequent amendment?

Mr Jim Wilson: Again, my verbatim memory is not with me. Did the government deal with some aspects of this in its amendments regarding discharge or transfer?

Mr Wessenger: No, we did not, Mr Wilson.

Mr Jim Wilson: I move that section 12 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 19.1:

"Discharge for transfer

"19.1.1(1) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home may apply, in accordance with the regulations, to the placement coordinator designated for the home or joint home, as the case may be, for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the home or joint home.

"Determination

"(2) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the home or joint home.

"Authorization

"(3) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the applicant on an appropriate alternative setting for the resident.

"Discharge

"(4) An applicant may discharge a resident of a home or joint home, as the case may be, when so authorized by a placement coordinator.

"Notice of determination

"(5) The placement coordinator shall serve a notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the home or joint home and determines not to authorize the resident's discharge, and subsections 19.1(2) to (7) apply with necessary modifications."

Again, this deals with the discharge or transfer of a resident currently residing in one home. That home may not be able to meet the needs of the resident. I know that the government, when this was introduced during our debate of the Charitable Institutions Act, said this amendment really isn't necessary, given that the homes can apply back to the placement coordinator for a transfer or a placement in the community, whatever is appropriate. But the opinion of homes themselves is that that's not good enough and they would like to see a mechanism in legislation that ensures them that the placement coordinator isn't just going to put someone into their home and not be required to respond to the ongoing needs of that resident.

1630

The Chair: Comments?

Mr Wessenger: We'll not be voting for this.

The Chair: Shall Mr Wilson's motion carry? All those in favour? Opposed? Defeated.

Now, I should have, I think, and I will now deal with—there's a Liberal amendment, but given that we have dealt with the Conservative amendment 19.1.1, which has just been defeated, I would ask Ms Sullivan to just refer to her amendment 19.1.1 and what her preference is there.

Mrs Sullivan: My amendment deals with a completely different area than that which the third party's amendment proposed.

The Chair: Then before dealing with that, we will go to your amendment 19.1(1), (2.1), (3), (4), (5).

Mr.Jim Wilson: And (7).

The Chair: And (7). If you would be good enough.

Mrs Sullivan: I move that subsection 19.1(1) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Notice of determination

"(1) A placement coordinator who makes a determination whether an applicant is eligible for admission to a home shall serve on the applicant a notice of determination."

And I further move that section 19.1 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection:

"Contents of notice

"(2.1) A notice of determination of eligibility under subsection (1) shall inform the applicant of,

"(a) the priority level for the person's admission;

"(b) the requirement set out in subsection (5) for entitlement to a hearing by the appeal board; and

"(c) the requirement set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing."

And I further move that subsections 19.1(3), (4), (5) and (7) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by striking out

"determination of ineligibility" everywhere it appears and substituting "determination."

We believe that the people who have applied to be assessed for eligibility for admission to a home have the right to know both whether they are determined to be eligible and whether they're determined to be ineligible for admission, and that the contents of the notice to them should include substantial information about the right to appeal and the time lines with respect to that appeal.

Mr Wessenger: We will not be voting for the motion.

The Chair: I then move Ms Sullivan's motion. All those in favour? All those opposed? The motion is defeated.

Ms Sullivan, we'll then deal with your amendment 19.1.2 and 19.1.3.

Mr Wessenger: What about 19-

The Chair: We will come to that. We'll deal with 19.1.1 first.

Mrs Sullivan: Section 12 of the bill?

The Chair: Yes.

Mrs Sullivan: Okay. I move that section 12 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 19.1:

"Notice of determination to person seeking admission

"19.1.1(1) A placement coordinator who determines that a person's admission to a home should not be authorized shall serve a notice of determination on the person.

"Applicable provisions

"(2) Subsections 19.1(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (1).

"Hearing by appeal board

"(3) A person who is served with a notice of determination is entitled to a hearing by the appeal board if the person mails or delivers to the placement coordinator and to the appeal board, within 30 days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(4) Subsections 19.2(1), (2), (3) and (5) apply, with necessary modifications, with respect to a hearing requested by a person under subsection (3).

"Powers of appeal board

"(5) After a hearing by the appeal board, the appeal board may,

"(a) affirm the determination made by a placement coordinator;

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the person's admission to the home."

To the broad TV audience that is watching this, it sounds like a lot of gobbledegook. In fact what we are saying is that a person who has applied for entry to a home for the aged should have the right to know whether or not he has been found to be eligible to enter that home, which

is included in the bill, but also should have the right to know whether he has been authorized for admission.

If he has been found eligible but not authorized for admission, in other words, if the placement coordinator says, "Yes, you should be in a home and you are eligible to be in that home," but then says, "No, you can't be in that home," the person should have the right of appeal, and that's what this amendment does.

Mr Jim Wilson: I want to just express my support for the amendment. I think it's a commonsense approach to this process and I think people deserve to know where they stand, whether or not they're authorized for admission. I'll leave it at that.

Mr Wessenger: We will not be voting for this amendment.

The Chair: Shall Ms Sullivan's motion carry? All those in favour? Opposed? Defeated.

Ms Sullivan, your last one in this grouping, 19.1.2 and 19.1.3.

Mrs Sullivan: I think this is an important motion.

I move that section 12 of the bill be amended by adding the following sections to the Homes for the Aged and Rest Homes Act, after section 19.1.1:

"Discharge for transfer

"19.1.2(1) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home or a board of management of a home may apply, in accordance with the regulations, to the placement coordinator designated for the home for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the home.

"Notice to resident

"(2) The applicant shall give notice of the application to the resident.

"Determination

"(3) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the home.

"Authorization

"(4) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the resident on an appropriate alternative setting for the resident.

"Discharge

"(5) An applicant may discharge a resident of a home when so authorized by a placement coordinator if an appropriate alternative setting for the resident is available and transfer to that setting is consented to by the resident or by a person authorized to consent on behalf of the resident.

"Notice of determination

"(6) The placement coordinator shall serve a notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the home and determines not to authorize the resident's discharge. "Applicable provisions

"(7) Subsections 19.1(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (6).

"Hearing by appeal board (discharge)

"19.1.3(1) A municipality or board of management that is served with a notice of determination under subsection 19.1.2(6) is entitled to a hearing by the appeal board if the municipality or board of management mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

(2) Subsections 19.2(1), (2), (3) and (5) apply, with necessary modifications, with respect to a hearing required by a municipality or board of management under subsection (1).

"Powers of appeal board

"(3) After a hearing by the appeal board, the appeal board may,

"(a) affirm the determination made by the placement coordinator:

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the resident's discharge."

1640

The Chair: Comments? Mr Wilson.

Mr Jim Wilson: Thank you, Chair. Just to indicate that we'll be supporting this amendment. It's similar in part to the PC amendment I put forward just a few minutes ago. However, it goes even a little further in terms of allowing a facility access to an appeal process if the placement coordinator determines that indeed the resident's care needs can be met in the home. The home may dispute that and can of course go to appeal, and for that reason, and the other stated previously, I support this.

Mr Wessenger: We will not be voting for this amendment.

The Chair: I'll put Ms Sullivan's motion then. Shall the motion carry? All those in favour? Opposed? It's defeated.

Mr Wilson, yours I think is even-

Mr Jim Wilson: Just before I might read this into the record, Mr Chairman, to make it clear, has the government made similar amendments regarding the 21-day provision, whereas my amendment talks about 90 days?

Mr Wessenger: Yes, that is correct.

Mr Jim Wilson: I won't be introducing this amendment.

The Chair: Okay. So your proposed amendment 19.2(1.1) is not moved?

Mr Jim Wilson: That's so.

The Chair: The next then would be the government amendment. No? Yes? I believe so.

Mr Wessenger: I move that subsections 19.2(1) and (2) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Hearing

"19.2(1)"—

The Chair: Sorry, can I just interrupt? You're reading from a white copy. Is it not a yellow one now?

Mr Wessenger: Have I got the wrong one?

Ms Czukar: Most people here would have yellow one.

The Chair: Okay, but his is white.

Ms Czukar: If you have a yellow one with a "2-JG" in the right upper corner, you've got the right one.

The Chair: Okay. "2-JG." Sounds like junior lieutenant or something. Sorry, just the indulgence of the Chair while I try to find—

Mr Wessenger: You can have this copy.

The Chair: Wait, here we are. Yes, we're fine. Thank you.

Mr Wessenger: I might be reminded where I left off in my reading.

The Chair: Why don't you start again. The Chair has thrown you off.

Mr Wessenger: I move that subsections 19.2(1) and (2) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Hearing

"19.2(1) When the appeal board receives an application for a review of a determination of ineligibility, it shall promptly appoint a time and place for a hearing.

"Same

"(2) The hearing shall begin within twenty-one days after the day the appeal board receives the application for the hearing, unless the parties agree to a postponement.

"Notice to parties

"(2.1) The appeal board shall notify each of the parties of the time and place of the hearing at least seven days before the hearing begins.

"Parties

"(2.2) The parties to the proceeding before the appeal board are the applicant who was determined to be ineligible for admission, the placement coordinator who made the determination and such other parties as the appeal board specifies.

"Notice to the minister

"(2.3) When a placement coordinator is notified by the appeal board of a hearing, the placement coordinator shall promptly give the minister written notice of the hearing together with written reasons for the determination of ineligibility made by the placement coordinator.

"Minister entitled to be heard

"(2.4) The minister is entitled to be heard by counsel or otherwise in a proceeding before the appeal board under this section."

This again is the same as was in the previous act, the Charitable Institutions Act, and sets out—

The Chair: Thank you. Any comments? If not, shall the government motion carry? All in favour? Carried.

Then the Conservative motion, 19.2(4).

Mr Jim Wilson: I think the government has a motion before mine

Mrs Sullivan: So have the Liberals.

The Chair: Subsection 19.2(3).

Mr Wessenger: I move that subsection 19.2(3) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Quorum of appeal board

"(3) Three members of the appeal board constitute a quorum and are sufficient for the exercise of the jurisdiction and powers of the appeal board under this act."

Again, I might add, this complies with what was passed in the previous act.

The Chair: Shall the government motion carry? All those in favour? Opposed? Carried.

The government also has an amendment to 19.2(4).

Mr Wessenger: I move that subsection 19.2(4) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out.

The Chair: All those in favour?

Mr Jim Wilson: I just want to comment that we're supporting this and it's identical certainly to the PC amendment and I think to the Liberal amendment.

The Chair: All those in favour? Opposed? Carried. I then have a PC amendment and a Liberal amendment.

Mr Jim Wilson: The PC amendment won't be introduced.

The Chair: The Liberal?

Mrs Sullivan: As my motion is identical to that of the government, I won't be putting it forward.

The Chair: Okay. Those are both not moved. We then come to a government amendment.

Mr Wessenger: This is 19.2(5.1) to (5.4)?

The Chair: Yes.

Mr Wessenger: I move that section 19.2 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsections, after subsection (5):

"Evidence of disabled person

"(5.1) If a party to a proceeding before the appeal board under this act wishes to give evidence in the proceeding or wishes to call another person as a witness to give evidence in the proceeding, but the party or other person is unable to attend the hearing by reason of age, infirmity or physical disability, the appeal board members holding the hearing may, at the request of the party, attend upon the party or the other person, as the case may be, and take his or her evidence.

"Medical report proves inability

"(5.2) A medical report signed by a legally qualified medical practitioner stating that the practitioner believes that the person is unable to attend the hearing by reason of age, infirmity or physical disability is proof, in the absence

of evidence to the contrary, of the inability of the person to attend the hearing.

"Opportunity for all parties

"(5.3) No appeal board member shall take evidence from a party or other person under subsection (5.1) unless reasonable notice of the time and place for taking the evidence is given to all parties to the proceeding and each party attending is given an opportunity to examine or cross-examine the party or other person, as the case may be.

"Recording of evidence

"(5.4) The oral evidence taken before the appeal board at a hearing and the oral evidence taken from a party or other person under subsection (5.1) shall be recorded and, if required, copies of a transcript of the evidence shall be furnished on the same terms as in the Ontario Court (General Division)."

The Chair: Any comments on this motion?

Mrs Sullivan: I just want to confirm something with the parliamentary assistant; I know we dealt with a similar motion in the charitable homes bill. Under the international protocols, is "infirmity" the appropriate word or is "impairment" the appropriate word that should be used here?

Mr Wessenger: I can only ask legislative counsel.

Ms Czukar: "Impairment" could be used instead of "infirmity," but this wording is taken from the provisions in the Nursing Homes Act that currently allow this kind of evidence to be given in this way.

1650

Mrs Sullivan: The only reason I put it on the table—and I didn't catch it in the previous bill—is that there are World Health Organization standards and definitions with respect to whether one is infirm, impaired, incapable etc. If we're using the wrong word, there could be difficulties with interpretation, because the CPSO standards are those of the World Health Organization.

Ms Czukar: I don't think that legally there would be a problem with it. It would be interpreted according to the section, and the medical report stating that the practitioner believes the person is unable to attend the hearing by whatever reason would be proof that the person can't attend. It wouldn't depend on a technical interpretation of the meaning of those terms.

Mr Jim Wilson: We will be supporting this amendment.

The Chair: I'll put the government motion. All those in favour? Opposed? Carried.

The next one is the government motion to subsection 19.2(6).

Mr Wessenger: I move that subsection 19.2(6) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Health Insurance Act

"(6) Subsections 23(1), (2), (4), (5) and (6) of the Health Insurance Act apply to the proceedings and decisions of the appeal board under this act."

The Chair: Any comments? I'll put the motion. Shall the government motion carry? All those in favour? Opposed? Carried.

Ms Sullivan, you have an amendment to the same subsection?

Mrs Sullivan: I'm not going to put it.

The Chair: Mr Wilson, vou're next.

Mr Jim Wilson: Given that the government has thwarted all attempts to improve the appeal mechanisms of this legislation, I won't be moving the amendment to subsection 19.2(7), which is essentially a housekeeping motion regarding appeal.

The Chair: Either one or just the first one? I have two amendments of yours.

Mr.Jim Wilson: Neither will be moved.

The Chair: All right. Just for the record, neither is

We then go to a government amendment, subsection 19.2(7.1).

Mr Wessenger: I move that section 19.2 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by adding the following subsection after subsection (7):

"Decision and reasons

"(7.1) The appeal board shall render its decision within one day after the end of the hearing and shall provide written reasons to the parties within seven days after rendering the decision."

The Chair: Any comment on the government amendment? No. Shall the government motion carry? All those in favour? Opposed? Carried.

Then the Conservative motion, Mr Wilson, section 19.2.1.

Mr Jim Wilson: Again, this refers to a previous attempt to improve the appeal mechanisms under this act, and as they weren't accepted by the government, I won't be moving this amendment.

The Chair: Thank you, Mr Wilson; not moved. There is a further amendment. Mr Wilson, yours is next.

Mr Jim Wilson: For the same reasons, this amendment won't be moved.

The Chair: Same reason, not moved. Then a government motion to section 19.5.

Mr Wessenger: I move that section 19.5 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be amended by striking out "and" at the end of clause (c) and by adding the following clause after clause (c):

"(c.1) an opportunity to participate fully in the development and revision of the resident's plan of care is provided to the resident, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct; and"

Mr Jim Wilson: I'll just indicate that we will be supporting this amendment. I think it ensures consumer

involvement or involvement of the resident's substitute decision-maker.

Mrs Sullivan: We still feel there is a gap, in that the associated consent with respect to implementation isn't attached to this particular section.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

We then have three Liberal amendments to the same section 19.5(d).

Mrs Sullivan: I move that clause 19.5(d) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out.

Mr Chairman, once again I put that the plan of care, although it may be developed by a multidisciplinary team associated with the home, is not necessarily solely provided by the home, and this subsection of this bill would require that the entire plan of care be provided to the resident in the home by the home. It's impractical and impossible.

Mr Jim Wilson: Mr Chairman, I think the Liberal motion is redundant, given that we've already passed a government motion that talks about ensuring that the consumer is involved in the development of the plan of care. I would think that if you're involved in the development, you're very much aware of it. I really don't like to see clauses added to legislation that may not be necessary.

Mrs Sullivan: The critic for the third party must be talking about a different amendment. This amendment would require the home to ensure that the plan of care is provided whether or not the home is responsible for certain aspects of the delivery of the plan of care. I suggest to you, by example, that if part of the plan of care is rehabilitation in a hospital, the nursing home or the home for the aged cannot possibly be held accountable for the portion of the plan of care that it will not be providing.

Mr Jim Wilson: Mr Chairman, when this was dealt with under the Charitable Institutions Act, I was satisfied at the time, but I do stand to be corrected, that the government had incorporated the principle in Mrs Sullivan's amendments—because there are really three to this section—in its own amendments. I would like to hear comment from the parliamentary assistant on that.

Mr Wessenger: Mr Wilson, with respect, I think you're looking at the next amendment, which is 19.5(2) and (3), in which it was covered.

The Chair: It is late in the day.

Mr Jim Wilson: I'm having a great debate with myself.

The Chair: Those are the most fascinating.

Mr Jim Wilson: I was doing well up to this point.

The Chair: I think we're all debating with ourselves. Shall Ms Sullivan's motion carry? All in favour? All opposed? Defeated. Ms Sullivan, your next amendment.

Mrs Sullivan: Mr Chairman, I have, as you know from your pile, two similar amendments. The first I will not present, but I will present the second one.

The Chair: Okay. The first one then will not be moved, and the next one will be. Please go ahead.

Mrs Sullivan: I move that clause 19.5(d) of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"(d) the care outlined in the plan of care, for which the municipality, the municipalities or the board of management is responsible for providing under the service agreement or a contract with the resident, and for which the municipality, the municipalities or the board of management has been compensated, is provided to the resident."

This becomes much more specific in outlining the standards which will be and should be expected of the home in terms of providing a guarantee or ensuring services which are provided to the resident.

1700

Mrs O'Neill: I ask this specifically of the parliamentary assistant: If this amendment does not pass, the fact of the matter is that the costs of the plan of care, which you sometimes describe as open-ended, will go to the local taxpayer in each community in this province. Is that the bottom line if this amendment doesn't go?

Mr Wessenger: No, the plan of care is established by the facility.

Mrs Sullivan: I'd like to point out that if this amendment doesn't pass, what will in fact occur is that the plans of care, which, as the parliamentary assistant indicates, are drafted by the facility, will be incomplete. They will not refer to any portions of treatment or course of treatment or rehabilitation which ought and should be an integral part of the plan of care but which is provided either offsite or is not covered in the level-of-care funding from the ministry to the home.

There is a singular problem with this section of the bill. The home cannot guarantee parts of the plan of care which it is not responsible for delivering, is not paid for delivering, does not have the qualifications to deliver, or that should be delivered offsite. Therefore, those elements, which ought to be included in a plan of care, will be left out of the plan of care and the resident will have what is an incomplete plan of care, for which approval has to be granted. No matter whether the resident is participating in the development or not, the home is left in the position of having to say to the resident on each occasion, if something is left out, "Well, sorry, that cannot be part of the plan of care, because we cannot be responsible for ensuring that that is provided."

I really believe that the government should revisit this section, not only in this section of the bill but in the previous section and in the subsequent section.

Mr Jim Wilson: Now that I'm with you on this section, I think Mrs Sullivan raises a very serious concern, which I would say is better explained at this time than it was when we were dealing with the Charitable Institutions Act. I wouldn't mind hearing the parliamentary assistant's response.

Mr Wessenger: I think it's all very speculative to determine what level any plan of care is going to provide. It's

certainly a fact that plans of care will be delivered relevant to the financial capabilities of the institution—I think that's fair to say—and will be tailored in line with the financial ability to provide the plans of care.

Mrs O'Neill: In this discussion it's very important that we bring forward that these facilities, the homes for the aged, are the ones that are going to be red-circled. If you remember, the term used by the municipalities that presented to us was: Where is the government going? "The lowest common denominator." That's the difficulty with this particular bill in this particular direction. Mrs Sullivan brings it—certainly not speculatively. We've had testimony on this issue.

The Chair: I'll put Ms Sullivan's motion. All those in favour? All those opposed? It is defeated.

We then move, Ms Sullivan, to your next amendment, which is 19.5(2) and (3).

Mrs Sullivan: Mr Chairman, I'm looking for advice from counsel as to whether this has already been included in the government motion or if it is yet to come.

The Chair: Which counsel were you looking at?

Mrs Sullivan: Any one.

Mr Wessenger: I'll ask counsel to respond, but I do believe it relates to plan of care.

Ms Czukar: It relates to the government motion that added paragraph (c.1) to the provision regarding plan of care to ensure resident participation.

Mrs Sullivan: Thank you. As it has been dealt with, I will not put this motion.

Mr Jim Wilson: Mr Chairman, just a comment on the motion that isn't being moved: This is the one that I felt was redundant. So hurry up, you guys; you're way behind.

The Chair: You're just ahead of us.

Ms Sullivan, 19.5.1: another one that may or may not be—

Mrs Sullivan: I move that section 12 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 19.5:

"Immunity for employees

"19.5.1. No proceeding for damages shall be commenced against an employee of a home or joint home for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in good faith of the person's duty."

I'd like a recorded vote.

Mr Jim Wilson: I'll be supporting, as I did when we were dealing with the Charitable Institutions Act. For the record, I can't believe the government would not be supporting immunity for employees.

The Chair: We'll put the motion; recorded vote. Shall Mrs Sullivan's motion carry? All those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

Navs

Hope, O'Connor, Owens, Wessenger, Wiseman.

The Chair: The motion is defeated.

Government motion 19.6.

Mr Wessenger: I move that section 19.6 of the Homes for the Aged and Rest Homes Act, as set out in section 12 of the bill, be struck out and the following substituted:

"Ouality management

"19.6. A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall ensure that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the home or joint home, as the case may be."

The Chair: Any comments?

Mr Jim Wilson: Again, as I commented during our discussion of the previous section of the bill dealing with the Charitable Institutions Act, I will be supporting this amendment, with the reservation given that I think it attempts to delineate what element should become part of a quality management plan when indeed experts in the field tell us that the latter part of the motion is really not necessary and in fact may be an impediment to a good-quality management program.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Mrs Sullivan, what do you wish to do with your motion?

Mrs Sullivan: I won't be putting my motion forward.

The Chair: The last two we'll deal with here. Under section 12. Mr Wilson.

Mr Jim Wilson: Given that the government's amendment we just passed deals with quality management, I won't be putting forward my amendment either.

The Chair: Either one?

Mr.Jim Wilson: Either one.

The Chair: Not moved, 19.6(1), and not moved, 19.6(2).

Shall section 12 of the bill, as amended, carry? Carried. Because there are no amendments to section 13, shall section 13 of the bill carry? Carried.

We will begin tomorrow morning with section 14. I want to thank the members for a long day and for cooperation. We will meet here tomorrow morning at 9:30 and complete our proceedings. The committee is adjourned.

The committee adjourned at 1709.



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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Présidente suppléante: Vice-Chair / Vice-Président: Daigeler, Hans (Nepean L)

Drainville, Dennis (Victoria-Haliburton ND)

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*Owens, Stephen (Scarborough Centre ND)

White, Drummond (Durham Centre ND)

Wilson, Gary (Kingston and The Islands/Kingston et Les Îles ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

Witmer, Elizabeth (Waterloo North/-Nord PC)

Substitutions present / Membres remplaçants présents:

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer

Jamison, Norm (Norfolk ND) for Mr Drainville

O'Connor, Larry (Durham-York ND) for Mr Gary Wilson

Perruzza, Anthony (Downsview ND) for Mr Drainville

Sullivan, Barbara (Halton Centre L) for Mr Daigeler

Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Wiseman, Jim (Durham West/-Ouest ND) for Mr White

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Quirt, Geoffrey, acting executive director, joint long term care division, Ministry of Health and Ministry of Community and Social Services

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Staff / Personnel:

Gottheil, Joanne, legislative counsel Spakowski, Mark, legislative counsel

^{*}In attendance / présents





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Thursday 25 March 1993

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Jeudi 25 mars 1993

Standing committee on social development

Long Term Care Statute Law Amendment Act, 1993

Comité permanent des affaires sociales

Loi de 1993 modifiant des lois en ce qui concerne les soins de longue durée



Chair: Charles Beer Clerk: Douglas Arnott Président : Charles Beer Greffier : Douglas Arnott



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 25 March 1993

The committee met at 0934 in room 151.

LONG TERM CARE STATUTE LAW AMENDMENT ACT, 1993

LOI DE 1993 MODIFIANT DES LOIS EN CE QUI CONCERNE LES SOINS DE LONGUE DURÉE

Consideration of Bill 101, An Act to amend certain Acts concerning Long Term Care / Loi modifiant certaines lois en ce qui concerne les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. We convene the standing committee on social development. We're considering Bill 101, An Act to amend certain Acts concerning Long Term Care. We had concluded to the end of section 13 yesterday. We now go to section 14 and begin with government amendments; in fact we have two government amendments. Parliamentary assistant, if you would begin.

Mr Paul Wessenger (Simcoe Centre): I move that the definition of "record" in subsection 21(1) of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding, after "form" in the last line, "but does not include that part of a record that deals with quality management activities or quality improvement activities."

This is to exempt from inspection those records dealing with quality management activities or quality improvement activities. The ministry inspectors do not currently review records with respect to these activities.

Mr Jim Wilson (Simcoe West): Mr Chairman, as was the case during our review of the Charitable Institutions Act, I would like an assurance from the parliamentary assistant that the wording of this amendment, which speaks to quality management activities or quality improvement activities, does indeed include peer review activities.

Mr Wessenger: I would confirm that legal counsel have previously confirmed that in their opinion peer review is included within the quality management definition.

Mr Jim Wilson: Thank you.

The Chair: I would then put the question. All those in favour of the government motion? Opposed? Carried.

Mr Wessenger, you have the next one.

Mr Wessenger: I move that clause 21(2)(b) of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be struck out and the following substituted:

"(b) may, if he or she has reasonable grounds to believe that records or other things pertaining to a home are kept in a place that is not in the home, enter the place at all reasonable times in order to inspect such records and other things." This adds the requirement that an inspector should have reasonable grounds and conforms with what was done in the Charitable Institutions Act.

The Chair: Discussion? I'll put the motion then. Shall Mr Wessenger's motion carry? All in favour? Carried.

We then go to the Liberal amendment.

Mrs Barbara Sullivan (Halton Centre): I won't be placing this amendment as the government has accepted the provision of warrant in other places in the bill.

The Chair: The amendment that follows is also yours. Ms Sullivan.

Mrs Sullivan: I won't be putting this amendment either for the same reason.

The Chair: Not moved. Mr Wilson, the next two are yours.

Mr Jim Wilson: I too won't be placing this amendment because I think the government's amendment puts further safeguards in place to ensure that inspectors do have a warrant and have a reason for inspection.

The Chair: Both of those motions then are not moved. We then come back to a Liberal amendment.

Mrs Sullivan: I move that section 21 of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding the following subsections:

"Exception, solicitor-client privilege

"(5.1) Subsection (5) does not override any solicitorclient privilege to which a record is subject.

"Exception, law enforcement

"(5.2) An inspector is not entitled to have access to a record or part of a record whose disclosure could reasonably be expected to produce one of the results described in subsection 14(1) of the Freedom of Information and Protection of Privacy Act (law enforcement).

"Exception, personnel records, quality review, etc

"(5.3) An inspector is not entitled to have access to a personnel record or to a record or part of a record dealing with.

"(a) quality review activities;

"(b) peer review or performance review activities; or

"(c) quality improvement activities."

While we have had the assurance of the parliamentary assistant that peer review activities are included in exempted records, I would rather see something that is more formal and included in the legislation and I would also prefer to see the solicitor-client and law enforcement provisions specifically included in the legislation. They are understood, we're told, but there is too much "understood" about this entire bill and the entire process here.

The Chair: I'll then put the Liberal motion. All those in favour? Opposed? Defeated.

We then move to a government motion.

Mr Wessenger: I move that the French version of section 14 of the bill be amended by striking out "À la demande de la municipalité" in the first line and substituting "À la demande d'une municipalité."

This is a correction to the French.

The Chair: Government motion, all in favour? Carried. We have a Conservative motion.

Mr Jim Wilson: I move that section 21 of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding the following subsection:

"Limitation on inspectors' powers

"(5.1) Subsection (5) does not give an inspector the authority to conduct an examination or test on an individual."

Again, this is to ensure that the term "examination" as used in the original drafting of Bill 101—

The Chair: Excuse me, Mr Wilson. I apologize.

Mr Jim Wilson: Wrong one?

The Chair: We just have a momentary confusion here. Did you have—

Mr Jim Wilson: I withdrew the previous one.

The Chair: Subsection 21(5.1)?

Mr.Jim Wilson: Yes.

The Chair: That's me, the Chair's.

Mr.Jim Wilson: No. I--

The Chair: You withdrew that.

Mr Jim Wilson: I withdrew 21(2.1).

The Chair: You withdrew both-

Mr Jim Wilson: Subsections 21(2) and (3).

The Chair: And 21(5.1)? Mr.Jim Wilson: No.

The Chair: Okay, then I'm in error. I'm sorry. I thought you had—

Mr Jim Wilson: I just withdrew the one, Mr Chair.

The Chair: Fine. The Chair apologizes. We are dealing with 21(5.1). Would you mind presenting that again, please.

Mr Jim Wilson: I move that section 21 of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding the following subsection:

"Limitation on inspectors' powers

"(5.1) Subsection (5) does not give an inspector the authority to conduct an examination or test on an individual."

Again, it's to clarify the terminology of "examination" used in the bill.

Wilson's motion? All those opposed? Defeated.

Mr Wilson, if you would then go on to your next one,

The Chair: Thank you. All those in favour of Mr

Mr Wilson, if you would then go on to your next one, 21(12).

Mr Jim Wilson: I move that subsection 21(12) of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by inserting after "at the inspector's request" in the fourth and fifth lines, "and at a time that is mutually agreed upon."

Again, this is an attempt by my caucus to ensure that, first of all, in no way the requirements by health professionals to assist inspectors is in any way limited. On the

other hand, we feel this would add some goodwill to this section of the bill to ensure that health care professionals' schedules are respected. I think it's reasonable that the inspectors, through this legislation, be asked to meet with health care professionals at a mutually agreed-upon time.

The Chair: Thank you. I'll put the motion. All those in favour of Mr Wilson's motion? All those opposed? Defeated.

Mr Wilson, the next one is yours, 21(12.1).

Mr Jim Wilson: I move that section 21 of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding the following subsection after subsection (12):

"Reimbursement of expenses

"(12.1) The minister shall reimburse the municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home for all extraordinary expenses incurred in the preparation, production and interpretation of records for an inspector."

The Chair: Thank you, Mr Wilson. This motion would be out of order under section 56.

A government motion next, 21.0.1.

Mr Wessenger: No, 21(15).

The Chair: Subsection 21(15). Sorry, right.

Mr Wessenger: I move that section 21 of the Homes for the Aged and Rest Homes Act, as set out in section 14 of the bill, be amended by adding the following subsection:

"Inspection report

"(15) Upon completing an inspection under this section, an inspector shall prepare an inspection report and shall give a copy of the report to each municipality maintaining and operating a home or to the board of management of the home, as the case may be."

Mr Jim Wilson: Did we not have a government 21(8) which dealt with the French version?

The Chair: Yes, we did and it was passed.

Mr Jim Wilson: How did I vote?

The Chair: Ouickly.

Mr Jim Wilson: I was looking forward to Mr Wessenger's pronunciation of the French language.

The Chair: We all enjoyed it. Il était très bien.

Mr Jim Wilson: Je m'excuse, Monsieur.

The Chair: Pas de problème. Which takes us back to 21(15).

Mr Jim Wilson: Oui.

The Chair: Do you wish to comment?

Mr Jim Wilson: Non.

The Chair: I'll move the motion, then. All those in favour of the government motion? Opposed? Carried.

Now there's also a Conservative motion 21(15).

Mr Jim Wilson: I think it'd be appropriate to not introduce that motion.

The Chair: Okay, that is not moved. Government motion—I think now we're at 21.0.1.

Mr Wessenger: I move that section 14 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 21:

"Warrant

"21.0.1(1) A justice of the peace may issue a warrant authorizing an inspector named in the warrant to enter premises specified in the warrant and to exercise any of the powers mentioned in subsection 21(5), if the justice of the peace is satisfied on information under oath that.

"(a) the inspector has been prevented from exercising a right of entry to the premises under subsection 21(2) or has been prevented from exercising a power under subsection 21(5); or

"(b) there are reasonable grounds to believe that the inspector will be prevented from exercising a right of entry to the premises under subsection 21(2) or will be prevented from exercising a power under subsection 21(5).

"Expiry of warrant

"(2) A warrant issued under this section shall name a date on which it expires, which date shall not be later than thirty days after the warrant is issued.

"Extension of time

"(3) A justice of the peace may extend the date on which a warrant issued under this section expires for an additional period of no more than thirty days, upon application without notice by the inspector named in the warrant.

"Use of force

"(4) An inspector named in a warrant issued under this section may use whatever force is necessary to execute the warrant and may call upon a police office for assistance in executing the warrant.

"Time of execution

"(5) A warrant issued under this section may be executed only between 8 am and 8 pm, unless the warrant specifies otherwise.

"Other matters

"(6) Subsections 21(4) and 21(6) to (15) apply with necessary modifications to an inspector executing a warrant issued under this section."

The Chair: Comments? Shall the government motion carry? All in favour? Opposed? Carried.

Ms Sullivan, we then have a Liberal motion. I believe it's the same—

Mrs Sullivan: I think we have some government motions before mine. Is that correct?

The Chair: Sorry, just one second.

Mrs Sullivan: I can tell you now that when we do reach my motion on the warrants, I will not be putting it forward, if that's of assistance to you.

Interjection.

The Chair: We have some confusion here.

Mr Wessenger: It's 21.0.2, Charles.

The Chair: Yes, sorry. We showed the one that is 21.1 as 21.0.1 on the warrant.

Mr Wessenger: That was ours.

The Chair: Yes, but the Liberal motion that reads, "Section 14 of the bill (section 21.1..." should read "21.0.1,"

and we should deal with it now, and I believe that's the one you said you would withdraw.

Mrs Sullivan: I'm not putting that motion forward.

The Chair: It's not moved and we then go to the government motion, which is 21.0.2.

Mr Wessenger: I move that section 14 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 21.0.1:

"Personal information

"21.0.2.(1) For the purpose of complying with sections 21 and 21.0.1, a head and an institution are authorized to disclose personal information to an inspector.

"Definitions

"(2) In this section, 'head,' 'institution' and 'personal information' have the same meaning as in the Municipal Freedom of Information and Protection of Privacy Act."

This amendment authorizes the municipal home to disclose personal information to an inspector and this amendment ensures that the inspection provisions are consistent among all the homes under the Municipal Freedom of Information and Protection of Privacy Act. Municipal homes may not disclose personal information unless disclosure is expressly authorized in other statutes. In other words, this is to make the provisions the same for municipal homes as they would be for charitable institutions and nursing homes. If we didn't have this, there would be a differing standard.

Mrs Sullivan: I'd like some further discussion of this motion, because there is not a comparable motion under the Charitable Institutions Act, and I understand why. However, the government did refuse to accept my motion which referred to the provincial freedom of information act, which may well apply to the nursing homes and the charitable institutions with respect to the law enforcement provisions. I think we need additional explanation of this particular section, which is not included in either of the other two bills.

Mr Wessenger: I'll ask legal counsel if she can add anything to what I've indicated.

0950

Ms Gail Czukar: Gail Czukar, legal counsel with the Ministry of Health. The provincial Freedom of Information and Protection of Privacy Act would not apply to charitable institutions or nursing homes, because they're private facilities. The municipal freedom of information and protection of privacy act does apply to municipal homes, because they're operated by municipalities, and under that statute the municipality would not be permitted to disclose any personal information within the meaning of the statute to the inspectors. This section is intended to override that so that the inspectors will have access to the same kinds of information they do in charitable homes and nursing homes.

Mrs Sullivan: At what point then under the provincial law, because the inspectors are provincial employees, does the provincial freedom of information law kick in, and what protection is there for personnel of nursing homes or of charitable homes which are not protected by freedom of

information laws that their records will not be disclosed? I know that I'm moving away from this particular section, but we have not discussed the protection of personnel records with respect to employees of homes in any circumstance.

Ms Czukar: Because they work for the ministry, any information that the inspectors collect or have access to or use would be covered by freedom of information and protection of privacy legislation, so they would be bound by that act to keep the information confidential and private and wouldn't be able to disclose it. The information will be able to go to the inspectors, but it will not be able to go further and that's the protection for the information that's gathered from the homes.

The Chair: I'll put the motion then. Shall the government motion carry? All in favour? Opposed? Carried.

Mr Wessenger, section 21.2.

Mr Wessenger: I move that section 14 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 21.1:

"Protection from reprisals

"21.2(1) No person shall do anything, or refrain from doing anything, in retaliation for another person making a disclosure to an inspector, so long as the disclosure was made in good faith.

"No interference

"(2) No person shall seek, by any means, to compel another person to refrain from making a disclosure to an inspector.

"Offence

"(3) Any person who contravenes subsection (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10.000 for each subsequent offence."

The Chair: Any comments? Shall the government motion carry? All in favour? Opposed? Carried.

We then move to the Liberal amendment, 28(1.1).

Mrs Sullivan: I move that section 28 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding the following subsection:

"Payments must be sufficient"-

Mr Jim Wilson: Mr Chairman, there is a PC motion prior to that, I think.

The Chair: Wait. We're into 17.

Mr Wessenger: So shouldn't we pass 14?

The Chair: Yes, sorry. Just before we do that then, we have dealt with all of section 14 now. Nothing has been deferred. Shall section 14 of the bill pass, as amended? Carried.

Let's then deal with section 15 of the bill. Carry? Carried.

Shall section 16 of the bill—

Mr Jim Wilson: Mr Chairman, I just want to make a comment. There were a couple of PC amendments to sections 16.1, 16.2.

Mr Wessenger: It might be a new section.

Mr Jim Wilson: It's a section not dealt with in the bill, so I suspect you may rule it out of order, but I just want to make a comment, if I may.

Mr Wessenger: We can deal with that, because 16.1 is a new section

The Chair: I'm sorry, I don't have—

Mr Jim Wilson: It's just for the committee members' information. It was a couple of motions dealing with capital funding. My comments with regard to this topic when we dealt with the Charitable Institutions Act stand and I will not be introducing these two amendments.

The Chair: Just for the record, that's section 16.1, subsection 25(2); and section 16.2, section 27 of the Homes for the Aged and Rest Homes Act.

Mrs Sullivan: Just for background, we would not have supported them had they been introduced.

Mr Jim Wilson: If I may comment on that, it is a contentious issue, except that I remind everyone that the attempt there was to show both the Liberal Party's and the government's illogical approach to these matters. The whole intent of this bill is to have a level playing field now between the three home sectors—the nursing homes, charitable homes and municipal homes—yet we're going to continue to have a bias in favour of charitable and municipal homes and against nursing homes when it comes to capital funding. We think, as a question of fairness, that it is self-evident this is unfair. I'll leave it at that. Mr Chairman.

The Chair: We will then put section 16. Shall section 16 carry? All in favour? Opposed? Carried.

Now we move to section 17.

Mrs Sullivan: I move that section 28 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding the following subsection:

"Payments must be sufficient

"(1.1) The payments under subsection (1) must be in such amounts that the payments, together with any amounts for which residents are responsible, are sufficient to defray all the costs described in subsection (1)."

This amendment is put forward to ensure that the payments from the ministry which are to be applied—

The Chair: Excuse me, Ms Sullivan, this is out of order.

Mrs Sullivan: That's a shame, because it's an important amendment.

The Chair: You can move to your next amendment, which is 28(2).

Mrs Sullivan: I move that subsection 28(2) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"Service agreement

"(2) No payment shall be made under subsection (1) inless.

"(a) the municipality, each of the municipalities or the board of management receiving the payment is a party to a service agreement with the crown in right of Ontario that relates to the home or joint home; and "(b) the service agreement complies with this act and the regulations."

As was previously the case, this is an attempt to fix a drafting error—

The Chair: Ms Sullivan, this is also out of order.

Mrs Sullivan: I don't believe so, Mr Chairman. We passed it in the previous bill.

The Chair: Then I must be out of order.

Mrs Sullivan: I think the government's willing to accept it. It's to correct a drafting mistake.

Mr Wessenger: I think we need to correct some—I must ask legal counsel to suggest some language changes in it.

Ms Czukar: Just as a matter of drafting, because this is the Homes for the Aged and Rest Homes Act and we have different entities operating homes, it should say, "The municipality, each of the municipalities or the board of management, as the case may be" and going on in the same paragraph, (2)(a) "receiving the payment is a party to a service agreement with the crown in right of Ontario that relates to the home or joint home, as the case may be."

I think legislative counsel would confirm that we need those words.

Mrs Sullivan: I would be pleased to add those words, depending on what the Chair would like.

The Chair: And I would be pleased to put it back in order.

Mrs Sullivan: Okay. Shall I withdraw the previous motion and re-read? Is that what you'd like for the record?

The Chair: Perhaps that would be best. Do you have that friendly amendment to read?

Mrs Sullivan: Yes, I do.

The Chair: Okay, go ahead, please.

Mrs Sullivan: I then withdraw the previous amendment, and I move that subsection 28(2) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"Service agreement

"(2) No payment shall be made under subsection (1) unless,

"(a) the municipality, each of the municipalities or the board of management, as the case may be, receiving the payment is a party to a service agreement with the crown in right of Ontario that relates to the home or joint home, as the case may be; and

"(b) the service agreement complies with this act and the regulations."

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The Chair: Shall the motion carry? Carried.

We then move to the government motion, subsection 28(3).

Mr Wessenger: I move that subsection 28(3) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding, before "the municipalities" in the third and fourth lines, "any of," and striking out "is or are in breach of" in the sixth and seventh lines and substituting "has breached."

This change takes into consideration the fact that a municipality may not be in breach of the service agreement. I think this is the one indicating the technical aspect of ensuring that there are no difficulties with respect to the legal aspects of prosecuting or determining that a breach has occurred.

Mrs Sullivan: Once again, we want it on the record that we will not be supporting this amendment because we feel there is too much uncertainty in the introduction of the words "has breached," which may refer to even a technical breach which occurred at some point in the past and about which there is no record

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

We then turn to the Conservative motion, sections 28.1 and 28.2, Mr Wilson.

Mr Jim Wilson: I move that section 17 of the bill be amended by adding the following sections to the Homes for the Aged and Rest Homes Act after section 28:

"Notice before reduction or withholding

"28.1(1) Before reducing or withholding a payment under subsection 28(3), the minister shall serve on the municipality, the municipalities or the board of management, as the case may be, a notice setting out,

"(a) the minister's proposal to reduce or withhold a

payment under subsection 28(3);

"(b) the proposed amount of the reduction or the amount proposed to be withheld, as the case may be;

"(c) the breach or breaches of the service agreement on which the minister relies for reducing or withholding payment:

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board;

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the municipality or the board of management, as the case may be, at its most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) A municipality or a board of management that is served with a notice under subsection (1) is entitled to a hearing by the appeal board if it mails or delivers to the minister and to the appeal board, within thirty days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If no hearing is required in accordance with subsection (4) by the municipality maintaining and operating the home, by any of the municipalities maintaining and operating the joint home or by the board of management of the home, as the case may be, the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) A municipality or board of management may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal board,

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for

the extension; and

"(b) may give such directions as it considers proper in light of the extension.

"Hearing

"(7) If a municipality or a board of management requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

"(9) The parties to a proceeding before the appeal board under this section are:

"(a) the municipality, municipalities or board of management requiring the hearing;

"(b) the minister; and

"(c) such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 19.2(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section.

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal;

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to make a reduction or withholding under subsection 28(3) in such lower amount;

"(b) may, if the minister has carried out the proposal under subsection (5),

"(i) find that the proposal was reasonable in the circumstances:

"(ii) direct the minister to pay to the municipality, the municipalities or the board of management, as the case may be, the amount of the reduction or the amount withheld, as the case may be: or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the municipality, the municipalities or the board of management, as the case may be, the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable;

"(c) may substitute its opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on appeal

"28.2 On an appeal to the Divisional Court from a decision of the appeal board under section 28.1, the Divisional Court.

"(a) may affirm or rescind the decision of the appeal

"(b) may substitute its opinion for that of the minister or the appeal board; and

"(c) may exercise all the powers of the appeal board."

The Chair: Any discussion?

Mr Jim Wilson: Again, Mr Chairman, as was the case during our review of the Charitable Institutions Act, this is a good attempt, I think, by me and my colleagues to ensure that there is some fairness introduced in this act, that if the minister is going to withhold operating money to homes, a notice be given to that home, and that the home have the right of appeal, which I think is fundamental in our democracy. I would hope that the government, since it didn't during the review of the Charitable Institutions Act seek to act on this motion in a significant way, will reconsider its previous position.

Mrs Sullivan: Mr Chairman, we strongly support the motion of the third party in this particular area.

The Chair: I'll put the motion. All those in favour of Mr Wilson's motion? All those opposed? Defeated.

We then move to the Liberal motion, 29.1.

Mrs Sullivan: I will not be putting that forward, Mr Chairman.

The Chair: Thank you. Not moved. We go to your next amendment. Ms Sullivan.

Mrs Sullivan: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 30:

"Term of service agreement

"30.0.1(1) Each service agreement shall be for a oneyear term.

"If no new service agreement

"(2) If a new service agreement is not entered into before the expiry of the current service agreement the following provisions apply:

"1. Despite subsection (1), the current service agreement continues in force until a new service agreement is entered into or until the current service agreement is

terminated.

"2. Any new service agreement that is entered into shall be deemed to have been in force since the current service agreement would have, but for paragraph 1, ceased to be in force.

"3. Interest shall be paid on all unpaid amounts that, under the new service agreement, should have been paid during the time the new service agreement is deemed to have been in force."

This motion is to ensure that the municipal homes are paid for the period of time during which a service agreement is being negotiated at the new rate, when the new rate is agreed to, and that interest is paid on moneys which have to be borrowed to ensure the operating costs are met during that period of time.

Mr Jim Wilson: Mr Chairman, before you rule the motion out of order, I just want to express my support for it.

The Chair: And I therefore do rule it out of order. No, I shouldn't say "therefore." The Chair was a little slow, Ms Sullivan. That should have been ruled out of order.

Mr Randy R. Hope (Chatham-Kent): Why are you ruling it out of order?

Mr Wessenger: The payment.

The Chair: The payment at the last part, number 3.

Mr Hope: Just for consistency for the record, because you've always indicated why you ruled something out of order.

The Chair: It's under section 56 of the standing orders, but specifically the third clause.

Now, Ms Sullivan, let's see what we have in this next one. This is section 30.0.2.

Mrs Sullivan: This one is in order, Mr Chairman, I will assure you before I read it.

The Chair: Just one moment. The next one I have is section 30.0.2. Is that what everyone has?

Mrs Sullivan: That's the one I have.

The Chair: Just one second. Do you have that now? Okay? Fine, go ahead.

Mrs Sullivan: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act, after section 30.0.1:

"Arbitration where failure to negotiate service agreements

"30.0.2(1) The municipality maintaining and operating a home, the municipalities maintaining and operating a joint home or the board of management of a home may require an arbitration by the appeal board, by giving notice in accordance with subsection (2), if there has been a failure to successfully negotiate.

"(a) an initial service agreement;

"(b) a subsequent service agreement; or

"(c) amendments to a service agreement in response to changing circumstances.

"Notice requiring arbitration

"(2) To require an arbitration, a notice requiring an arbitration must be mailed or delivered to the minister and to the appeal board.

"Arbitration

"(3) If the appeal board receives a notice under subsection (2), the appeal board shall arbitrate the matters in dispute.

"Parties

"(4) The parties to an arbitration are the person requiring the arbitration and the minister.

"Applicable provisions

"(5) Subsections 19.2(3) and (5) apply, with necessary modifications, with respect to an arbitration.

"Powers of appeal board

"(6) In arbitrating the matters in dispute the appeal board may order the minister,

"(a) to sign on behalf of the crown in right of Ontario, a service agreement with such terms as the appeal board specifies; or

"(b) to sign on behalf of the crown in right of Ontario, an agreement that amends an existing service agreement in such manner as the appeal board specifies."

This motion is to require a different action from the appeal board, which is one of dispute resolution and arbitration, when there is difficulty that cannot be solved through direct negotiation between the ministry and the home which is negotiating the service agreement or when the patient classification and case mix index has changed so substantially that negotiations are necessary.

Mr Jim Wilson: I just want to express my support for this amendment. It speaks to a very important element that's currently missing in Bill 101, and that is the right of arbitration. You'll note that the next PC amendment also speaks to that. I would like to say, once again, that the government has really refused opposition attempts to put in a significant appeal mechanism when it comes to negotiating the terms of a service agreement or giving some fairness and some balance and some rights to facilities. I think it's a fairly heavy-handed manner in which the government goes about putting in place service agreements.

The government tells us it wants to be consultative, but, again, operators of facilities and municipalities are asking us, if the government is so sure that there won't be a lot of problems in the future, why it is afraid of allowing significant appeal mechanisms in this part of the bill and allowing arbitration if needed? So I would like the parliamentary assistant to expand on what he means by the appeal mechanisms that the government will seek to bring forward during phase 2.

Mr Wessenger: The details of the type of appeal mechanism have not yet been considered. It will have to be done through consultation with stakeholders. So there are no specific proposals at this stage of how it would be dealt with.

Mr Jim Wilson: Perhaps we could have a further explanation from the parliamentary assistant, if for no other reason than for the record, to try and convince us or tell us once again why the government does not want appeal mechanisms such as we've proposed and arbitrations such as opposition parties have proposed.

Mr Wessenger: I think it's fair to say that the government would not be in favour of an arbitration system with respect to these items. I think the preference for dealing with the matter would be some type of appeal process. As I said, this is without prejudice to the matter being considered, but I am expressing a personal opinion here. I would expect some form of administrative board procedure would be the one that would be most looked at for whatever consideration and would be examined with stakeholders to see what jurisdiction and what items would be subject to appeal, and so forth, of the procedure with respect—we're only surmising here, because it hasn't really been worked on. No proposal has be worked on. Until the end of the consultation with the groups, you're not going to have something more specific.

Mr Jim Wilson: The important question is, what happens in the interim before you bring forward phase 2—it's not clear to me or I think really to anyone else when that's going to happen—of your long-term care reform legislation? What will happen in the meantime? We were told in the government's selling of this legislation that it was an attempt to bring fairness into the system, and it was certainly along that vein. One would think you would not want nursing homes, municipalities, charitable homes, for example, to have to resort to court action in the interim, given that there are no appeal mechanisms allowed, or arbitration. I'd like the parliamentary assistant's comment on that.

It was brought to my attention many times yesterday by nursing home operators that in the interim all they can see is that if they get into a conflict with the government surrounding service agreements, they'll have to resort to the courts. That's an expensive and I think very onerous position to put operators in.

Mr Wessenger: I'm advised that we've had enhancement contracts with nursing home operators for years. There's never been, I understand, a case of a court matter. The matters have usually been dealt with by negotiation and all matters have been resolved, I understand, without the necessity of going to the court. But the court is the ultimate if the situation does arise. Certainly, from past experience, I am advised there has not been a problem with these contracts.

Mrs Sullivan: I think it's very clear that the past experience will in fact not be a reference point for future experience. The entire funding mechanism is changing. The requirements that are placed on the homes are changing. The contractual relationship is changing.

What we have heard through the hearing process is that homes themselves wanted a less formal, more flexible approach so that disputes with respect to agreements could be placed on the table and that residents also wanted a less formal approach to dealing with disputes. What we see under this act is an inflexible, formal, confrontational, litigious system.

Any changes that the government has made to date to the bill will only add to that. They will increase the time lines, they will increase the cost and they will increase the adversarial nature of any resolution of disputes. We feel that is very inappropriate and we are really concerned when the parliamentary assistant tells us that any changes will have to wait for a later phase, for phase 2, when we don't even know when phase 2 will finally come forward. We haven't really even seen phase 1 at this point.

1020

Mr Wessenger: The only comment I would make on that is the fact that how matters are administrated is not a matter of how legislation reads, and certainly I would concur with the intention of trying to have dispute resolution informally set up to deal with matters. I'm sure the ministry is of the same view.

The Chair: Thank you. Shall the motion put by Ms Sullivan carry? All in favour? Opposed? The motion is defeated.

We next move to the Conservative motion, 30.0.1.

Mr Jim Wilson: I move that clause 30—I'm sorry. Did that get renumbered?

The Chair: No. Your next one should be 30.0.1. You may have to just flip ahead in your package. We've got them a little bit out of order.

Mr Wessenger: Could I just ask for a point of clarification here? I have some motions before me, and I wonder if they've been withdrawn: 30(1)(c) and 30(1)(a). They're PC motions

The Chair: No. To help members, we're going to deal—the Chair apologizes. Mr Wilson, we will go to 30(1)(a), then to 30(1)(c) and then to 30.0.1, which I think is the way you have them.

Mr Jim Wilson: Thank you. I move that clause 30(1)(a) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"(a) shall provide that it continues in full force and effect until replaced or cancelled in accordance with the regulations;

"(a.1) shall contain a dispute resolution mechanism for resolving disputes related to the service agreement;

"(a.2) shall provide for a right to arbitration if the dispute resolution mechanism fails to resolve a dispute;

"(a.3) shall contain the other provisions required by the regulations to be contained in a service agreement."

Just once again, Mr Chairman, I think it's a mistake by this government not to allow more fairness into this section of the act with regard to service agreements. There should be a dispute resolution mechanism so that homes do not have to resort to the courts and there should be a right to arbitration, and there also should be stipulated, even though we've been told it may not be necessary, that any existing service agreement remains in force until it's replaced by a new one.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

We will then move to your next motion, Mr Wilson, 30(1)(c).

Mr Jim Wilson: As it follows from the previous motion, Mr Chairman, I will not introduce it.

The Chair: Okay, that motion is not moved, and then to your next one, 30.0.1.

Mr Jim Wilson: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 30:

"Arbitration

"30.0.1(1) This section applies with respect to arbitrations under a service agreement.

"Notice

"(2) An arbitration is commenced by a party to a service agreement giving written notice to the other party of its desire to arbitrate a dispute related to the service agreement.

"Appointment of board of arbitration

"(3) Within fourteen days of the written notice having been given, the parties,

"(a) shall jointly appoint a member of the appeal board to sit as a board of arbitration; or

"(b) shall each appoint a person to sit on the board of arbitration.

"Same

"(4) If the parties each appoint a person to sit on the board of arbitration, the two persons so selected shall within ten days after the second of the persons has been appointed, appoint a member of the appeal board.

"Powers of board of arbitration

"(5) The board of arbitration shall hold a hearing to examine and decide the matters that are in dispute between the parties.

"Service agreements

"(6) Any decision of the board of arbitration shall form part of the service agreement.

"Costs

"(7) The board of arbitration may award costs.

"Appeal to Divisional Court

"(8) A party may appeal a decision of the board of arbitration to the Divisional Court on a question of law or fact or both.

"Powers of court on appeal

"(9) On an appeal to the Divisional Court from a decision of the board of arbitration under this section, the Divisional Court may do any one or more of the following:

"1. Affirm or rescind the decision of the board of arbi-

"2. Substitute its opinion for that of the board of arbitration.

"3. Exercise any power of the board of arbitration."

Mr Chairman, I think my previous comments with respect to this matter stand.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? The motion is defeated.

We then go to government motion 30.1(1)(a).

Mr Wessenger: I move that clause 30.1(1)(a) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by striking out "for basic accommodation" in the first line and substituting "for a class of basic accommodation."

Again, this is to allow for the different rates to short-term and long-term basic accommodation.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Government motion 30.1(1)(e).

Mr Wessenger: I move that clause 30.1(1)(e) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"(e) for care, services, programs or goods that are not mentioned in clause (a), (b), (c), (d) or (2)(a) and in respect of which the resident has entered into a written agreement with the municipality, the municipalities or the board of management, as the case may be, the amount determined in accordance with the written agreement."

This complies with the change in the Charitable Institutions Act.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Government motion 30.1(2)(b).

Mr Wessenger: I move that clause 30.1(2)(b) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by striking out "or on behalf of" in the fifth line.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Government motion 30.1.1.

Mr Wessenger: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 30.1:

"Deht"—

This will not be moved.

The Chair: Withdrawn, not moved.

Mrs Sullivan: Mr Chairman, could I have some clarification on just where the government intended to go with this motion, even though it's not put, because it seems to me that we've had a number of public statements with respect to resident charges being based on income and not on assets. This motion as it is drafted would lead us to believe that the government in fact is changing its direction in that matter, and it seems to me that should be an issue of public record.

Mr Wessenger: No, this is not what it's about. This is to ensure that there is a legal obligation on the part of the resident to the home for the aged or the rest home, so that they can sue for the moneys owing on the accommodation.

Mrs Sullivan: Presumably the debt would fall to the estate?

Mr Wessenger: Yes, it would.

Mrs Sullivan: Which would move it then to the asset issue, I suggest to you.

Mr Wessenger: If people do not pay their accommodation liability that they're obliged to pay, then that would accrue, obviously, as a debt.

The Chair: Just to make sure we all understand then-

Mr Wessenger: It's covered by your amendment who is responsible for it, so it's similar.

The Chair: The government motion 30.1.1 is not moved. We now move to the proposed Liberal motion 30.1.1.

Mrs Sullivan: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act:

"Resident responsible for payment for accommodation

"30.1.1(1) A resident is responsible for the payment of those amounts demanded in accordance with 30.1, by a municipality maintaining and operating a home, by municipalities maintaining and operating a joint home or by a board of management of a home, for accommodation.

"Minister to give statements

"(2) The minister shall provide, annually and on the request of a resident, a statement setting out how much the resident may be charged for accommodation under subsection 30.1(1)."

Mr Wessenger: Could we just hold for a minute to see whether legislative counsel is happy with this wording?

The Chair: Shall I put Ms Sullivan's motion? All in favour? Opposed? Carried.

Mrs Sullivan: I'm surprised.

The Chair: Some tentativeness there. We then move to the Conservative motion 30.2.

1030

Mr Jim Wilson: I move that section 30.2 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill be amended by adding the following subsection after subsection (1):

"No recovery of charge

"(1.1) No deduction shall be made under subsection (1) unless written notice about the fact that the item paid for has not been provided or made available to the resident is given to the minister within ninety days after the date on which the person for whom the payment was accepted discovers the fact."

Again, this is an attempt to ensure that after someone discovers that a service or item—because the next motion deals with services—was not properly provided to a resident, within 90 days the matter be dealt with so that it's not left for an indefinite period of time.

The Chair: Shall Mr Wilson's motion carry? Opposed? It is defeated. Mr Wilson, you have a further amendment to 30.2

Mr Jim Wilson: I move that section 30.2 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding the following subsection after subsection (2):

"No recovery of charge

"(2.1) No deduction shall be made under subsection (2) unless written notice about the fact that the payment exceeds the amount permitted to be charged under section 30.1 is given to the minister within ninety days after the date on which the person from whom the payment was accepted payment discovers the fact."

Again, I think it's a reasonable motion given that it's a 90-day time period after the discovery of the fact.

Mrs Yvonne O'Neill (Ottawa-Rideau): It should pass.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? It is defeated.

Mr Wilson, you have a further amendment to 30.2.

Mr Jim Wilson: The word "futility" does cross my mind from time to time.

I move that section 30.2 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding the following subsection after subsection (3):

"No recovery of charge

"(3.1) No deduction shall be made under subsection (3) unless written notice about the fact that the item paid for has been inadequately provided is given to the minister within ninety days after the date on which the person from whom the approved corporation accepted payment discovers the fact."

Again, these motions are important because operators do tell us that, for example, when a person is deceased and the operator is dealing with the family or loved ones in trying to clean up some of the bills that may be outstanding, from

time to time families refuse to pay operators of homes. They then hide under the act by indicating that perhaps the service wasn't provided properly, it was inadequate or the item was never received. It's a bit unfair.

All this simply does is introduce fairness, saying that after the discovery of the fact something was wrong or something was inadequately provided, in fairness to operators, families and residents, there be given 90 days to bring that forward and to rectify the situation. I don't see anything wrong with these amendments, and I don't know why the government won't support them.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? It is defeated.

We then move to a Liberal amendment 30.2.1

Mrs Sullivan: I move that section 17 of the bill be amended by adding the following section to the Homes for the Aged and Rest Homes Act after section 30.2:

"Restriction on reducing payments, etc

"30.2.1 The minister may not reduce or withhold payments under section 28 or deduct an amount from a payment under section 30.2 if the reduction, withholding or deduction would put a resident's safety, health or security at risk or would cause any of the services or programs in a resident's plan of care to be interrupted."

Mr Jim Wilson: I just want to express my support for this amendment. We've maintained all the way along that the real people who will be hurt—with respect to the government withholding funding for a breach of a service agreement, a breach of contract with a home—will be residents, and I think that amendment attempts to bring in some safeguards in that regard.

The Chair: Shall Ms Sullivan's motion carry? All in favour? Opposed? Defeated.

We then move to a Conservative motion, 30.2.1 and 30.2.2. Mr Wilson.

Mr Jim Wilson: I move that section 17 of the bill be amended by adding the following sections to the Homes for the Aged and Rest Homes Act, after section 30.2:

"Notice before deduction

"30.2.1(1) Before making a deduction under section 30.2, the minister shall serve on the municipality, the municipalities or the board of management, as the case may be, a notice setting out,

"(a) the minister's proposal to make a deduction under section 30.2:

"(b) the proposed amount of the deduction;

"(c) detailed reasons for making the deduction;

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board; and

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the municipality or the board of management, as the case may be, at its most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) A municipality or a board of management that is served with a notice under subsection (1) is entitled to a hearing by the appeal board if it mails or delivers to the minister and to the appeal board, within thirty days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If no hearing is required in accordance with subsection (4) by the municipality maintaining and operating the home, by any of the municipalities maintaining and operating the joint home or by the board of management of the home, as the case may be, the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) A municipality or a board of management may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal board,

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for

the extension; and

"(b) may give such directions as it considers proper in light of the extension.

"Hearing

"(7) If a municipality or a board of management requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

"(9) The parties to a proceeding before the appeal board under this section are,

"(a) the municipality, municipalities or board of management requiring the hearing;

"(b) the minister;

"(c) the person from whom the payment was accepted;

"(d) such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 19.2(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section.

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal;

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to deduct such lower amount under section 30.2;

"(b) may, if the minister has carried out the proposal under subsection (5).

"(i) find that the proposal was reasonable in the circumstances:

"(ii) direct the minister to pay the amount deducted to the municipality, the municipalities or the board of management, as the case may be; or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the municipality, the municipalities or the board of management, as the case may be, the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable;

"(c) may substitute its opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on appeal

"30.2.2 On an appeal to the Divisional Court from a decision of the appeal board under section 30.2.1, the Divisional Court.

"(a) may affirm or rescind the decision of the appeal board;

"(b) may substitute its opinion for that of the minister or the appeal board; and

"(c) may exercise all the powers of the appeal board."

Again, this is an attempt to introduce some fairness into this legislation, and I might as well say it before they do it: I'm extremely disappointed that the government doesn't support at least the thrust of this legislation at this time. I don't think we can wait for phase 2 for all the appeal mechanisms the government says it might bring forward.

1040

The Chair: Thank you, Mr Wilson. Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

Mr Wilson, you have a subsequent amendment to 30.2.

Mr Jim Wilson: I move that section 30.2 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by adding the following subsection after subsection (3):

"No recovery of charge

"(3.1) No deduction shall be made under subsection (3) unless written notice about the fact that the item paid for has been inadequately provided is given to the minister within ninety days after the date on which the person from whom the approved corporation accepted payment discovers the fact."

Mr Chairman, I won't reiterate my comments stated previously with respect to this matter.

The Chair: Thank you. Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

Mr Wilson, a further amendment to 30.3(1)(a)?

Mr Jim Wilson: I move that clause 30.3(1)(a) of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"(a) the rights and obligations of the resident and of the municipality, the municipalities or the board of management." Again, as was the case during our review of the Charitable Institutions Act, this is an attempt to put into this legislation the fact that not only do residents have significant rights, and that is properly so, but management, in this case the municipality or the municipalities or the board of management, also have rights with respect to this legislation.

Mrs Sullivan: Hear, hear.

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

Then government motion 30.3, Mr Wessenger.

Mr Wessenger: I move that section 30.3 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"Notice to residents

"30.3(1) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall give to each resident of the home or joint home, as the case may be, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct, a written notice.

"(a) setting out the rights of the resident under subsection 1.1(2) and stating that the municipality, each of the municipalities or the board of management, as the case may be, is obliged to respect and promote those rights;

"(b) describing the accommodation, care, services, programs and goods that the municipality, each of the municipalities or the board of management, as the case may be, is required to provide or offer under this act and under the service agreement relating to the home or joint home;

"(c) stating that the resident, the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care or such other person as they may direct may request access to and an explanation of the resident's plan of care, and specifying the person to whom such a request must be made;

"(d) setting out the procedures for making complaints about the maintenance or operation of the home or joint home, the conduct of the staff of the home or joint home or the treatment or care received by the resident in the home or joint home; and

"(e) setting out such other matters as are prescribed by the regulations.

"Obligations re plan of care

"(2) If a request is made in accordance with clause (1)(c), the municipality, the municipalities or the board of management shall ensure that access to and an explanation of the plan of care is provided to the person who made the request."

The Chair: Any comments?

Mrs Sullivan: With respect to this amendment and to others which deal with these service agreements which are being negotiated, I just want to place on the table that my colleagues and I have learned that there have been instructions or information to several area offices indicating that those area offices will be closed. We have been told that

service agreements will be put into place by area offices for the nursing home sector, along with people who are now employed as program supervisors under Comsoc.

In this motion we have a requirement that the accommodation, care, services etc that are included in the service agreement must be written down and the information about those services must be provided to the resident. In fact, what we may well be looking at is a significant post-ponement of long-term care, a situation where the contracts cannot indeed be negotiated, where in fact what we are now dealing with is a large case of fluff. We know that the ministry has recently asked for line-by-line accounting of existing expenses, which bears absolutely no relationship to level-of-care funding, nor to the development of a case mix index that's based on the classification of patients.

With this motion and with all of the other motions which have been on the table with respect to the service agreements, which are fundamental to the delivery of long-term care, it seems to me that we're being led up the garden path.

Mr Jim Wilson: Mr Wessenger, would you like to respond to that first? Mine is more pertaining to the motion.

Mr Wessenger: I'm not in a position to respond to all speculative comments. This provision purely relates to giving notice of rights to residents and their substitute decision-makers, and comments are not really relevant to this legislation.

Mr Jim Wilson: I'm sure Mrs Sullivan would like to take another crack at that, but in the meantime, I'd like to ask, just to ensure conformity to this government amendment, is a standard form being drawn up so that homes for the aged, rest homes, nursing homes and charitable institutions will be sure to provide all that's required in this motion in terms of a written notice—all that's required in the written notice—to the resident? Does the operating manual speak to that?

Mr Wessenger: Does the service manual speak to the-

Mr Jim Wilson: This requires written notice to the resident.

Mr Wessenger: Yes.

Mr Jim Wilson: I'm just wondering if there's a standard form being drawn up. Some of this is already in practice and some of it isn't. I understand there isn't uniformity; it depends on the home. I've been asked to ask you whether some standardization is going to be brought in, or whether every operator and administrator is going to have to read the act and try to figure out exactly what the heck the government wants.

Mr Wessenger: Okay, I'll ask counsel. She may be able to clarify.

Ms Czukar: Consideration is being given to developing a standard information package relating to the standard information; that is, the matter set out in the act and regulations. Of course, there would be information that's specific to each home regarding the specific services to be offered there and so on, but consideration is being given to assisting homes with being able to give the notice and having standard information being given to people where it's applicable.

Mr Jim Wilson: I appreciate that, because I think a standard form, where homes could simply fill in the blanks, personalizing it to their own home, would be appropriate to ensure that all residents across the province were treated equally.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Government motion 30.4.

Mr Wessenger: I move that section 30.4 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be amended by:

(i) renumbering clause (a) as clause (a.1) and adding the following clause:

"(a) a copy of section 1.1"; and

(ii) adding the following clause after clause (a.1):

"(a.2) a copy of the most recent inspection report relating to the home or joint home, as the case may be, received by the municipality, the municipalities or the board of management, as the case may be, under subsection 21(15)."

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Conservative motion 30.4

1050

Mr Jim Wilson: I move that section 30.4 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"Having documents available

"30.4(1) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall ensure that the following documents are available for inspection in the home or joint home, as the case may be:

"1. A copy of the service agreement relating to the

home or joint home, as the case may be.

"2. A copy of each of the financial statements, reports and returns filed under this act with the minister by the municipality, the municipalities or the board of management, as the case may be.

"3. All other documents required by the regulations to be available for inspection in the home.

"Notice to residents

"(2) The municipality, the municipalities or the board of management, as the case may be, shall post a notice in the home informing residents how they can inspect the documents referred to in subsection (1)."

Again, to refer to my earlier remarks or my remarks of yesterday when we were dealing with the Charitable Institutions Act and the same section therein, this is an amendment which would ensure that residents and anyone entering a home would have full access to all the documents required by regulation and all the documents spelled out currently in the legislation and have them available for inspection. It is an attempt to perhaps make a neater package and a better presentation to residents, consumers and

families, to ensure that the aesthetics of the home are maintained to be exactly that of a home and that a common place be set aside for the inspection of these documents.

Again, I think it's a very reasonable request. It is not trying in any way to limit access to the necessary documents, but I think it's a more commonsense approach to this whole issue of posting documents in a home.

The Chair: Shall Mr Wilson's motion carry? All those in favour? Opposed? The motion is defeated.

Ms Sullivan, the Liberal motion, section 30.4.

Mrs Sullivan: I move that section 30.4 of the Homes for the Aged and Rest Homes Act, as set out in section 17 of the bill, be struck out and the following substituted:

"Availability of information

"30.4 A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall ensure that the following documents are made available in a prominent place in the home:

"1. A copy of the service agreement relating to the home.

"2. Copies of those financial statements, reports and returns filed with the minister that the regulations require to be made available.

"3. All other documents and information that the regulations require to be made available."

Once again, this amendment is put forward precisely to the issue of posting of information. We believe the requirement that the documentation be posted is one that is frankly silly. Having the required information available in a place where it's usable, perhaps at a desk, accessible without interference by management of the home, is an appropriate way of ensuring that residents and their families or others who are concerned with their care have access to the information but the place isn't a mass of wall clutter.

The Chair: Shall Ms Sullivan's motion carry? All those in favour? Opposed? Defeated.

We then move to the government motion, sections 30.5 to 30.10.

Mr Wessenger: I move that section 17 of the bill be amended by adding the following sections to the Homes for the Aged and Rest Homes Act after section 30.4:

"Residents' council

"30.5(1) If a request for the establishment of a residents' council is made to the administrator of a home or joint home by at least three persons, each of whom is a person mentioned in subsection (2),

"(a) the administrator shall promptly notify the director of the request;

"(b) the administrator shall promptly notify the municipality maintaining and operating the home, the municipalities maintaining and operating the joint home or the board of management of the home, as the case may be, of the request; and

"(c) the municipality, the municipalities or the board of management, as the case may be, shall assist the persons who made the request in establishing a residents' council for the home within sixty days of the request.

"Request for residents' council

- "(2) For the purpose of subsection (1), the following persons may request the establishment of a residents' council for a home or joint home:
- "1. A resident of the home or joint home, as the case may be.
- "2. A person who is lawfully authorized to make a decision on behalf of a resident of the home or joint home, as the case may be, concerning the resident's personal care.

"Right to be a member

- "(3) Subject to subsection (4), the following persons are entitled to be members of the residents' council of a home or joint home:
- "1. A resident of the home or joint home, as the case may be.
- "2. A person who is lawfully authorized to make a decision on behalf of a resident of the home or joint home, as the case may be, concerning the resident's personal care.
- "3. A person selected by the resident or by the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care.

"Who may not be a member

- "(4) The following persons may not be members of the residents' council of a home or joint home:
- "1. A member of the council of the municipality maintaining and operating the home, a member of a council of any of the municipalities maintaining and operating the joint home or a member of the board of management of the home, as the case may be.
- "2. The administrator of the home or joint home, as the case may be.
- "3. A member of the staff of the home or joint home, as the case may be.
- "4. Any other person who is responsible for the operation of the home and who is employed by the municipality maintaining and operating the home, by any of the municipalities maintaining and operating the joint home or by the board of management of the home, as the case may be.

"Appointment by minister

"(5) At the request of a residents' council, the minister may appoint no more than three persons to be members of the residents' council, and those persons shall serve as members at the pleasure of the residents' council.

"Same

"(6) Only a person who lives in the area in which the home or joint home is located and who is not employed by and does not have a contractual relationship with the ministry of the minister may be appointed under subsection (5).

"Meeting

"30.6(1) Unless a home or joint home has a residents' council, the municipality maintaining and operating the home, the municipalities maintaining and operating the joint home or the board of management of the home, as the case may be, shall, at least once in each year, convene a meeting of the residents and the persons who are lawfully authorized to make a decision on behalf of a resident concerning the resident's personal care, to advise them of their right to establish a residents' council.

"Results of meeting

"(2) Within thirty days after the meeting, the municipality, the municipalities or the board of management, as

the case may be, shall notify the director of the results of the meeting.

"Powers of residents' council

"30.7 It is the function of a residents' council of a home or joint home, and the council has the power, to,

"(a) advise residents of the home or joint home, as the case may be, respecting their rights and obligations under this act."

"(b) advise residents of the home or joint home, as the case may be, respecting the rights and obligations of the municipality maintaining and operating the home, the municipalities maintaining and operating the joint home or the board of management of the home, as the case may be, under this act and under the service agreement relating to the home or joint home, as the case may be:

"(c) meet regularly with representatives of the municipality, representatives of the municipalities or representatives of the board of management, as the case may be, to,

"(i) review inspection reports relating to the home or joint home, as the case may be, received by the municipality, the municipalities or the board of management, as the case may be, under subsection 21(15),

"(ii) review the allocation of money for accommodation, care, services, programs and goods provided in the home or joint home, as the case may be:

"(iii) review the financial statements relating to the home or joint home, as the case may be, filed with the minister under the regulations, and

"(iv) review the operation of the home or joint home, as the case may be:

"(d) attempt to mediate and resolve a dispute between a resident of the home or joint home, as the case may be, and the municipality maintaining and operating the home, the municipalities maintaining and operating the joint home or the board of management of the home, as the case may be; and

"(e) report to the minister any concerns and recommendations that in its opinion ought to be brought to the minister's attention.

"Residents' council assistant

"30.8(1) With the consent of a residents' council, the minister may appoint a residents' council assistant to assist the residents' council in carrying out its responsibilities.

"Dutie

"(2) In carrying out his or her duties, a residents' council assistant shall take instructions from and report to the residents' council.

"Information and assistance

"30.9(1) A municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall cooperate with the residents' council and the residents' council assistant and shall provide them with such financial and other information and such assistance as is required by the regulations.

"Obstruction

"(2) No person shall refuse entry to a home or joint home to a residents' council assistant or otherwise hinder, obstruct or interfere with a residents' council assistant carrying out his or her duties.

"Offence

"(3) Any person who contravenes subsection (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for each subsequent offence.

"Immunity

"30.10 No proceeding shall be commenced against a member of a residents' council or a residents' council assistant for any act done under section 30.7, unless the act is done maliciously or without reasonable grounds."

The Chair: Thank you. I should say, "Well done; deep breath." Any discussion of this motion? Shall the government motion carry? All in favour? Opposed? Carried.

Ms Sullivan, 30.5 to 30.9.

Mrs Sullivan: Mr Chairman, as my motion is virtually identical to that which the parliamentary assistant has just read and we just passed, I will not be putting mine forward.

1100

The Chair: So that is not moved. I would then ask, shall section 17 of the bill, as amended, carry? All in favour? Opposed? Carried.

Now we move to section 18. Shall subsection 18(1), as in the bill, carry? Shall subsection 18(2) carry? Carried. Shall subsection 18(3) carry? Carried.

Then we come to subsection 18(4). Mr Wessenger, there is a government amendment.

Mr Wessenger: I move that paragraph 15 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(4) of the bill, be struck out and the following substituted:

"15. requiring that parts of the bed capacity of homes and joint homes be set aside for various classes of accommodation, and regulating the amount of bed capacity that must be set aside for each class;"

This again is with respect to the short-term and long-term bed situation.

The Chair: Shall Mr Wessenger's motion carry? Carried.

Another government motion—sorry, wait a minute. We did subsection 18(4). Shall subsection 18(4), as amended, carry? Carried. Shall subsection 18(5) carry? Carried.

We come then to subsection 18(6). Mr Wessenger.

Mr Wessenger: I move that paragraph 18 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(6) of the bill, be amended by striking out "short-stay accommodation" in the third and fourth lines and substituting "short-stay program."

The Chair: Shall the government motion carry? Opposed? Carried.

We then have a Conservative amendment, subsection 31(1), Mr Jackson.

Mr Cameron Jackson (Burlington South): Subsection 31(1)? I have a subsection 18(6).

The Chair: Yes, subsection 18(6), but it's—

Mr Jackson: That's fine. I will not be tabling that motion, but the next one I will.

The Chair: Okay, not moved. I have a government motion first. Mr Wessenger.

Mr Wessenger: I move that paragraph 19 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(6) of the bill, be struck out and the following substituted:

"19. prescribing the maximum amounts or governing the manner of determining the maximum amounts that may be demanded or accepted from or on behalf of a resident under clauses 30.1(1)(a) and (b), prescribing the information or proof that is to be provided before a determination is made, requiring that the information provided for the purpose of a determination be provided under oath, and prescribing the persons or other entities who may make the determination:"

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Shall subsection 18(6), as amended, carry? Carried.

We will then move to subsection 18(7). First a government amendment, paragraph 31(1)26.

Mr Wessenger: I move that paragraph 26 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(7) of the bill, be amended by,

(i) adding, after "other" in the last line of subclause (i), "documents and"; and

(ii) striking out "and" at the end of subclause (i) and adding the following subclause after subclause (i):

"(i.1) requiring that the information provided by the municipality, the municipalities or the board of management, as the case may be, for the purpose of the reconciliation, be provided under oath, and"

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Mr Jackson, we then have the Conservative amendment.

Mr Jackson: I move that subparagraph (i) of paragraph 26 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(7) of the bill, be amended by striking out "audited financial statements, proof of maintenance and operating costs, information about the level of occupancy of the home" in the eighth, ninth, tenth and eleventh lines and substituting "proof of maintenance and operating costs, information about the financial affairs and the level of occupancy of the home."

Briefly, the concern here is that the interpretation of "audited financial statements" is a very, very expensive term and, as we have heard, the ministry is currently struggling with the requirement to have fully audited statements. It strikes me that we're subjecting these institutions to the interventions of CAs at great expense, which is an expense which accrues to the resident, ultimately, in the scheme of things, and that audited financial information, we've been led to believe, will satisfy the ministry's requirements. But quite frankly, this becomes a very expensive requirement, and if the government certainly now isn't fully up and equipped to deal with it, as it's indicated, then we think it presents an additional financial burden. We can still have a level of accountability and we can still have the government's ability to control and comprehend the financial status of any given institution at any one time without

going this extra step and extra expense, so we're proposing this amendment. If it's not supported by the government, perhaps it could modify at its own initiative the audited financial statements and just make that audited financial information. But the word "statement" means that a CA must intervene, and that becomes extremely expensive.

Mr Wessenger: I'd just indicate that this is permissive, not mandatory, and it's the regulatory power. I think it's very important that we maintain the right to require audited statements, so we will not be supporting it.

The Chair: Shall the Conservative motion carry? All in favour? Opposed? The motion is defeated.

We move on to another Conservative amendment.

Mr Jackson: I move that paragraph 28 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(7) of the bill, be struck out and the following substituted:

"28. governing service agreements, including their replacement and cancellation and including prescribing provisions that must be contained in all service agreements and matters that must be provided for in all service agreements."

As my colleague has indicated, this attempts to put in legislation more clarity than leaving it to regulation, the point of clarification we're raising here.

The Chair: Shall Mr Jackson's motion carry? All in favour? Opposed? It is defeated.

Shall section—sorry.

Mrs O'Neill: Before we take the vote on this, I'd just like to say about this whole section—

The Chair: I'm sorry, before we take a vote on—

Mrs O'Neill: —on this section, if I may make an intervention.

The Chair: May I call the section and then I'll recognize you?

Mrs O'Neill: Okay, thanks.

The Chair: We will then call the vote on subsection 18(7), as amended, Ms O'Neill.

Mrs O'Neill: I find the whole attitude of this section is really demeaning to municipalities. Certainly they have business plans, they have councils that they are responsible to and thence ratepayers, on a very regular basis. I would like to ask the parliamentary assistant, if I may, because I do find the part about the oath almost offensive. I can't believe why everyone in a municipality would have to provide things under oath. Who is going to be the witness to those oaths? Are they going to have to go beyond the municipal building to get the oaths, or is one municipal employee going to be witness to another? The whole thing just smacks of overkill.

Mr Wessenger: It's not really related to this motion, but—

Mrs O'Neill: Well, it's related to the section. Have you thought out how it's going to be implemented?

Mr Wessenger: It's a regulation-making power and it's permissive. It says the ministry may require oath; it doesn't say it will. So it will do it where it's appropriate.

Mrs O'Neill: Boy, that leaves the municipalities wondering if they're the appropriate one that's not going to be trusted and has to have an oath on the information they're going to provide to the government. This is something new; it's a big move. It may sound like very little. The municipalities are going to examine this; they're going to get all their legal authorities out and examine how this act is going to apply to them. All I am saying is that there's not much of a partnership being built here, which will then, in my mind, I'm sorry, hurt the individual residents because the service agreements are not going to be built on a good basis.

1110

The Chair: Shall subsection 18(7), as amended, carry? All in favour? Carried.

We then move to subsection 18(8).

Mr Jackson: I move that paragraph 32 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(8) of the bill, be struck out and the following substituted:

"32. governing applications to placement coordinators for a determination, including prescribing the placement coordinators to whom applications may be made and the frequency with which applications may be made;"

The Chair: Shall Mr Jackson's motion carry? All in favour? Opposed? The motion is defeated.

We have then Mr Wessenger, a government motion to subsection 31(1).

Mr Wessenger: I move that paragraph 34 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(8) of the bill, be struck out.

This deletes the regulation-making power requiring and governing consent to admission and care provided in the home.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

We then have a Liberal motion, subsection 31(1).

Mrs Sullivan: I move that subsection 18(8) of the bill be amended by adding the following paragraph to subsection 31(1) of the Homes for the Aged and Rest Homes Act:

"34.1 prescribing the qualifications for persons and entities to be designated as placement coordinators;"

This motion is placed to ensure that there is included in the regulation a description of the qualifications needed for either a person, an agency or other body to act as a placement coordinator.

Mr Wessenger: Might I ask if Ms Sullivan would consider withdrawing the motion in view of the fact that there is a government motion with respect to section 35.2 requiring that placement coordinators have certain qualifications and meet certain requirements. I think the language is more appropriate. I wonder if in the circumstance she might consider it.

Mrs Sullivan: I'll stand it down until we get to that one.

The Chair: Okay, this is deferred. We then continue with a Liberal amendment, again to subsection 31(1).

Mrs Sullivan: I think the government one comes first, does it—or am I wrong?

The Chair: We're just having a discussion on that The Chair is open to information. We can go ahead with the government motion. That may simplify life

Mr Wessenger: I move that paragraph 35 of subsection 31(1) of the Homes for the Aged and Rest Homes Act as set out in subsection 18(8) of the bill, be struck out and the following substituted:

"35, prescribing, for the purpose of clause 18(8.5)(c). additional circumstances which are grounds for a committee of management or a board of management to withhold approval for the admission of a person to a home or joint home:

"35.1 prescribing and governing the obligations of a committee of management and a board of management in relation to giving or withholding approval for the admission of a person to a home or joint home, and governing the written notice required to be given under subsection 18(8.6)."

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Mrs Sullivan: Given that the government motion is carried, we don't need my motion.

The Chair: To be clear, your motion being what?

Mrs Sullivan: To strike that section.

The Chair: Yes. Sorry. Not the one you deferred but your amendment-

Mrs Sullivan: No. the next one.

The Chair: Paragraph 35 of section 31 is not moved. Thank you.

Okay, then we go to the next government motion.

Mr Wessenger: I move that subsection 18(8) of the bill be amended by adding the following paragraph to subsection 31(1) of the Homes for the Aged and Rest Homes Act, after paragraph 35.1:

"(35.2) requiring that placement coordinators have certain qualifications or meet certain requirements and prescribing such qualifications or requirements."

The Chair: Shall the government motion carry? Opposed? Carried.

Mrs Sullivan: Now that the government motion has carried. I will withdraw the motion which I stood down respecting the qualifications of placement coordinators.

The Chair: Thank you. It's the motion you had deferred. It has now been withdrawn. We then move next to a Conservative amendment, Mr Jackson,

Mr Jackson: I move that paragraph 36 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(8) of the bill, be struck out and the following substituted:

"36. prescribing, for the purpose of section 30.4, the additional documents that must be available for inspection in the home, and governing the notice required to be posted under that section."

The Chair: Shall Mr Jackson's motion carry?

Interjections: No.

The Chair: Okay, defeated. Government motion.

Mr Wessenger: I move that paragraph 37 of subsection 31(1) of the Homes for the Aged and Rest Homes Act. as set out in subsection 18(8) of the bill, be struck out and the following substituted:

"37, governing short-stay programs in homes and joint homes.'

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Again government motion 31(1), Mr Wessenger.

Mr Wessenger: I move that paragraph 39 of subsection 31(1) of the Homes for the Aged and Rest Homes Act. as set out in subsection 18(8) of the bill, be struck out and the following substituted:

"39, governing the quality management system to be developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care. services, programs and goods provided to residents of homes and joint homes."

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

A Conservative motion to 31(1).

Mr Jackson: I move that paragraph 39 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(8) of the bill, be struck out and following substituted:

"39, governing quality management programs, including their development, implementation and revision;"

The Chair: Shall Mr Jackson's motion carry? All in favour? Opposed? Defeated.

A government motion to 31(1).

Mr Wessenger: I move that paragraph 40 of subsection 31(1) of the Homes for the Aged and Rest Homes Act, as set out in subsection 18(8) of the bill, be amended by striking out "of which notice must be given" in the third and fourth lines and substituting "which must be set out in the notice."

The Chair: All those in favour of the government motion? Opposed? Carried.

Again, government motion, Mr Wessenger.

Mr Wessenger: I move that subsection 18(8) of the bill be amended by adding the following paragraph to subsection 31(1) of the Homes for the Aged and Rest Homes Act, after paragraph 40:

"40.1 governing inspection reports."

The Chair: Shall the motion carry? All those in favour? Opposed? Carried.

Then, Ms Sullivan, Liberal motion to 40.1 and 40.2 of subsection 31(1).

Mrs Sullivan: I move that subsection 18(8) of the bill be amended by adding the following paragraphs to subsection 31(1) of the Homes for the Aged and Rest Homes Act:

"40.1 respecting the establishment and conduct of residents' councils:

"40.2 respecting the information, financial information and assistance a municipality maintaining and operating a home, the municipalities maintaining and operating a joint home and the board of management of a home shall give to a residents' council and a residents' council assistant;"

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The Chair: Shall Ms Sullivan's motion carry? All in favour? Opposed? Motion is defeated.

Government motion to 31.1.

Mr Wessenger: I move that subsection 18(8) of the bill be amended by adding the following paragraphs to subsection 31(1) of the Homes for the Aged and Rest Homes Act, after paragraph 40.1:

"40.2 respecting the establishment and conduct of residents' councils:

"40.3 respecting the financial and other information and the assistance that a municipality and a board of management must give to a residents' council and a residents' council assistant."

Mrs Sullivan: Just as a point of clarification, how does the government motion differ from the motion I just put and the government voted against?

Mr Wessenger: There's some difference in the language in 40.3. The intent is probably somewhat similar, but we wanted to have consistency in the bill.

Mrs Sullivan: You didn't want to accept an opposition amendment, that's why.

The Chair: What is it they say about consistency?

Shall the government motion carry? All opposed? Carried.

Shall section 18(8) of the bill, as amended, carry? Carried.

Shall section 18, as amended, carry? Carried.

I'm sorry, just step back. I need to ask you if section 18(9) shall carry. Carried.

Now, shall section 18 of the bill, as amended, carry? Carried.

We then move to a new section, 18.1. You'll recall that we dealt with government motion 32 yesterday and it carried.

Now then, shall section 19 of the bill carry as in the bill?

Interjection: No.

The Chair: No, sorry.

Mrs Sullivan: I think there's a government motion before this.

The Chair: Okay, just a minute. Hold it. Sorry, section 19 again: Shall section 19 as in the bill carry? Carried. Thank you.

Now we move to section 20. I have a government—

Mrs Sullivan: Mr Chairman, has the government already put—yes it has. Never mind.

The Chair: To ask a question is to answer it.

We then go to section 20 and a government motion to 17(b).

Mr Wessenger: I move that clause 17(b) of the Ministry of Community and Social Services Act, as set out in section 20 of the bill, be amended by adding after "grants" in the last line, "and requiring that information provided to the minister in connection with grants be provided under oath."

This again is permissive and allows that information can be required to be sworn if necessary.

The Chair: Shall the government motion carry? All those in favour? Opposed? Carried.

Shall section 20 of the bill, as amended, carry?

Mrs Sullivan: Just a minute, Mr Chairman. You're going a little fast here.

The Chair: All right, sorry. We've just dealt with government motion 17(b) to section 20. We've passed that and I was then going to put the question with respect to section 20. It's the Ministry of Community and Social Services Act

Mrs Sullivan: Right, and I think one of the things we wanted to put on the table was an objection with respect to the requirement that information be provided to the minister under oath. My colleague, I think, would like to speak to that as well.

The Chair: We have voted on that.

Mrs Sullivan: I understand that. We didn't have a chance to speak to it.

The Chair: We'll allow Ms O'Neill, if you—

Mrs O'Neill: I'm just speaking to the whole section.

The Chair: There's unanimous consent? Thank you.

Mrs O'Neill: I'm speaking to the whole section 19. I think the communities that came before us—

The Chair: I'm sorry, are you speaking to section 20?

Mrs O'Neill: No, 19.

The Chair: But we have dealt with 19.

Mrs O'Neill: Well, 19 and 20 then, the whole thing.

The Chair: All right, with unanimous consent.

Mrs O'Neill: I think the communities that came before us are going to be very sorry that we didn't hear them. This is the only part of the act where we could have intervened and the government could have intervened on the disabled issue. There were suggestions made and there were clarifications requested, whether they were disabled or whether they were the young, the children, where there is absolutely no mention in this act. The seniors are also feeling very fragile here and we have not clarified one thing for them, in my humble opinion.

The Chair: Shall section 20, as amended, carry? Carried.

Pardon me. Just let the Chair get organized here.

Mr Jim Wilson: Mr Chairman?

The Chair: Yes, Mr Wilson, as I try to find myself here.

Mr Jim Wilson: Before posing the question on section 21, I'd just like to make a comment on it.

The Chair: Go ahead.

Mr Jim Wilson: Section 21 of the bill deals with extended care facilities and really the whole issue of extended care services. I think the public should be aware that contrary to the government's stated intentions and contrary to anything it ever said while it was in opposition or on the campaign trail back in 1990, this bill, and it hasn't been dealt with to any great extent, really delists extended care services as an insured service under medicare.

I just want to place on the record in very strong terms that I and my caucus colleagues are not at all pleased to

see extended care being delisted without, as Minister Lankin promised me last year during a debate in the estimates committee, a full public debate. I think it's the beginning

of the slippery slope.

The Senior Citizens' Consumer Alliance for Long-Term Care Reform is having a press conference right now, next door, at which they talk about the end of medicare. They see it as two to three years away. They are aware that this is a delisting. They are also aware that the government has floated ideas about delisting other services such as reproductive services and in vitro fertilization. When Ms Lankin first became Health minister, we even had some scarier thoughts reported in the media that perhaps elderly seniors would no longer have access to medically necessary operations because the government was going to review the efficacy of such procedures.

I think, to be fair to the government, it's incumbent upon the government not to do this without a full public debate specifically on this. We had public hearings on this bill, but really the only association to comment in any strong terms at all was the Ontario Nursing Home Associa-

tion itself.

They pointed out to committee members that this was the first major delisting we've seen under medicare, and yet they were not able to pursue that matter in a forthright manner with this committee because of the catch-22 we're all in, which is that the government, along the process of introducing Bill 101, and by the time it got to committee here, tied future funding to the nursing home sector to the passage of this bill. They have a gun to our heads, as it were, as legislators. Given that residents will suffer if the money doesn't flow, it wouldn't be wise to hold up this legislation. On the other hand, I just want to make it clear to all members of the public that this is a significant matter, that extended care no longer exists in this province and that it is the slippery slope for the end of medicare and certainly flies in the face of anything the NDP ever said in the past.

1130

The Chair: Shall section 21 of the bill carry? Carried. Shall section 22 of the bill carry? Carried.

We come to section 23 of the bill, which is part VI, the Municipality of Metropolitan Toronto Act, and we have a government amendment.

Mr Wessenger: I move that section 23 of the bill be struck out and the following substituted:

"23. Section 186 of the Municipality of Metropolitan Toronto Act is repealed."

This section of the Municipality of Metropolitan Toronto Act provides that the municipality of Metropolitan Toronto is liable for the cost of maintaining an indigent person in a nursing home, once the board of management accepts the indigent person, if there's no bed available in the home for the aged. In light of the new funding formula, this section is no longer applicable.

Mrs O'Neill: I'd like to know where the representation on this matter came from and who is actually going to foot the bill now for the indigent person. I can't understand why it was presented when the bill was first presented, because I don't remember hearing any witnessing that would ask this to be struck. What is going on here?

Mr Wessenger: I understand the municipality of Metropolitan Toronto asked that it be struck. The fact is, the funding will be provided under the funding formula for all residents. If you want further explanation, I can certainly ask counsel to add anything.

Mrs O'Neill: I think it would be good to get it on the record, please.

Ms Czukar: What section 186 did was, if an indigent person was in a nursing home awaiting accommodation in a home for the aged, if the municipality had accepted the person for admission to the home for the aged but didn't have the bed yet, the municipality at that point acquired the financial responsibility for the person even though he was still in a nursing home. That is all irrelevant given that the province will fund both nursing homes and homes for the aged.

The municipality of Metropolitan Toronto requested that the section be repealed rather than amended to replace wording regarding placement coordinators making decisions, because it was irrelevant. Both the municipality and the Ontario Nursing Home Association have agreed that the section should be repealed.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 23 of the bill, as amended, carry? Carried. We will then move to section 24 of the bill. This is now part VII, the Nursing Homes Act. A Liberal amendment, Ms Sullivan.

Mrs Sullivan: I'm not going to be putting this motion forward because the government has defeated it in the other two bills. I think they're making a mistake, but I shan't be putting it forward anyhow.

The Chair: The Liberal amendment is not moved. Shall section 24 of the bill, as in the bill, carry? Carried.

We will then move to section 24.1. Mr Wessenger has a government amendment.

Mr Wessenger: I move that the bill be amended by adding the following section after section 24:

"24.1(1) Subsection 2(1) of the act is amended by striking out 'this act and the regulations' in the second and third lines and substituting 'this act, the regulations and a service agreement between the crown in right of Ontario and a licensee.'

"(2) Subsection 2(3) of the act is amended by striking out 'this act and the regulations' in the second line and substituting 'this act, the regulations and a service agreement relating to a nursing home.'

"(3) Subsections 2(4), (5), (6) and (7) of the act are repealed and the following substituted:

"Deemed contract

"(4) A licensee of a nursing home shall be deemed to have entered into a contract with each resident of the home, agreeing to respect and promote the rights of the resident as set out in subsection (2)."

The Chair: Comments?

Mrs Sullivan: I'd like some clarification and I think this is the appropriate place to do it because this particular motion, as well as others, of course, speaks about the licensees. Will nursing homes continue to be licensed?

Mr Wessenger: I will ask counsel to respond to that.

Ms Czukar: Yes.
Mrs Sullivan: Why?

Ms Czukar: First of all, this section deals with amendments to the bill of rights section so I'm not certain how this comes up under licensing, but if the question relates to signing a service agreement as a condition of funding and operating—I'm guessing. Is that the question? I'm not sure how it comes up under the bill of rights section.

Mrs Sullivan: What is occurring here is that you are changing the words "this act and the regulations" to "this act, the regulations and a service agreement between the crown...and a licensee." What I'm asking is why one would still have a licensing process, which seems to me to continue to maintain a bureaucratic treatment when indeed the contractual arrangement is now going to be between a nursing home and the government through a service agreement. What you are saying is that there will still be a licensing process on top of that. It seems bizarre to me. There's no other place I can ask this question because the word "licensee" is used throughout because the change hasn't been made to the Nursing Homes Act to eliminate the licensing process.

Ms Czukar: It's not unlike the Charitable Institutions Act, where the approved corporation must be approved in order to be able to operate a home for the aged, for example, or another kind of service as a charitable institution and still be required to sign an agreement with respect to the funding in particular and not be able to operate unless such an agreement has been signed. The approval or licensing process is an approval process that relates to certain kinds of conditions or requirements before the service agreement is negotiated.

Mrs Sullivan: I would suggest to you, respectfully, that as you're looking at phase 2, that's a question that should be examined. I think it's a process duplication that will add to the cost of administration when in fact the same requirements that are needed for licensing can be included or can be demanded through a service agreement and through the regulations.

Mr Wessenger: Perhaps I should indicate that I'll take the member's comments under consideration.

The Chair: Shall the government motion carry? All those in favour? Opposed? Carried.

We then move to section 25. I have a Liberal amendment to 4(2).

Mr Wessenger: I haven't got this one.

The Chair: One moment, please. There was a motion distributed yesterday, I believe.

Ms Sullivan, if you'd proceed.

Mrs Sullivan: The ministry likes this one, too. I move that subsection 4(2) of the Nursing Homes Act, as set out in section 25 of the bill, be struck out and the following substituted:

"Issuance of licence

"(2) No licensee shall operate a nursing home unless,

"(a) the licensee is a party to a service agreement with the crown in right of Ontario that relates to the home; and

"(b) the service agreement complies with the act and the regulations."

1140

The Chair: Sorry, "with this act"?
Mrs Sullivan: Counsel, "this"?

Ms Czukar: "The act."

Mrs Sullivan: Legislative counsel had written both words in.

The Chair: This was a test to see if we were really awake. So it's "with the act."

Mrs Sullivan: "With the act," all right.
The Chair: And "the regulations."

There was a suggestion that there was broad concurrence with this. Shall I put the motion? All those in favour? Opposed? Carried.

Shall section 25, as amended, carry? Carried. Shall section 26, as in the bill, carry? Carried. Section 27, government amendment to 13(a.1).

Mr Wessenger: I move that clause 13(a.1) of the Nursing Homes Act, as set out in section 27 of the bill, be amended by striking out "is in breach of its" in the first line and substituting "has breached the."

This is similar to the other amendments that have been made in the other act.

The Chair: Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 27, as amended, carry? Carried.

Then new section, 27.1, Liberal amendment, Ms Sullivan.

Mrs Sullivan: Mr Chairman, I won't be putting this motion.

The Chair: This motion is not moved.

We then move to section 28 and again a Liberal motion, to 20.1(2) and (2.1). Ms Sullivan.

Mrs Sullivan: I move that subsection 20.1(2) of the Nursing Homes Act, as set out in section 28 of the bill, be amended by striking out "classes of persons" in the second line.

I further move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Contract for payment

"(2.1) No person or entity may be designated by the minister as a placement coordinator unless a contract is being entered into between the person or entity and the minister on behalf of the crown in right of Ontario and the contract provides for the payment of the person or entity for acting as a placement coordinator."

The Chair: Ms Sullivan, that is out of order under section 56 of the standing orders.

Mrs Sullivan: Thank you, Mr Chairman.
Mr Jim Wilson: If I may, Mr Chairman—

The Chair: Mr Wilson, did you wish to make a comment?

Mr Jim Wilson: It may not be in order to comment on a motion that was out of order, but again I think Mrs Sullivan's motion that you've so ruled is extremely important because the whole question of who's paying for placement coordination has been left up in the air, and I have a funny feeling that with the record of this government, they're going to download that cost on to the institutions.

The Chair: I have a Liberal amendment, 20.1(2.2).

Mrs Sullivan: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

'Oualifications

"(2.2) No person or entity may be designated by the minister as a placement coordinator unless the person or entity meets the qualifications prescribed by the regulations."

The Chair: Shall Ms Sullivan's motion carry? All in favour? Opposed? Defeated.

Conservative motion, 20,1(5)(a).

Mr Jim Wilson: I move that clause 20.1(5)(a) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"(a) Within the six months preceding admission, a placement coordinator has determined that the person is eligible for admission to a nursing home; and"

Mr Chairman, I'd be prepared to withdraw this motion if I received assurance from the parliamentary assistant that the principle of this motion is being incorporated in the government's own amendments.

Mr Wessenger: This again was the one where the six months was incorporated in with section 8.4, which we haven't yet moved, of course.

Mr Jim Wilson: Thank you. Mr Chairman, I'll withdraw this motion.

The Chair: That motion will then not be moved. We go next to Liberal motion 20.1(5.1).

Mrs Sullivan: I think the government has a motion before that.

Mr Wessenger: I think we have one before that, 20.1(5) to (8.7).

The Chair: I do have that in front of me. I suggest we deal with the government motion because that may then expedite the number of others that are also listed, so we'll go to government motion 20.1(5) to (8.7).

Mr Wessenger: I move that subsections 18(5) to (8) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Admission

"(5) A licensee of a nursing home shall not admit a person unless the person's admission to the nursing home is authorized by the placement coordinator designated for the nursing home under subsection (3), and shall admit a person whose admission to the nursing home is so authorized.

"Applications to placement coordinator

"(6) A person may apply for a determination by a placement coordinator respecting the person's eligibility for admission to a nursing home and for authorization of admission with respect to such nursing home or homes as the person selects.

"Assistance

"(7) A placement coordinator who determines that a person is eligible for admission shall, if the person wishes, assist the person in selecting the nursing home or homes with respect to which the person will apply for authorization of admission.

"Person's preferences

"(8) In assisting a person under subsection (7), the placement coordinator shall consider the person's preferences relating to admission, based on ethnic, spiritual, linguistic, familial and cultural factors.

"Determination respecting eligibility

"(8.1) A placement coordinator shall determine whether a person is eligible for admission to a nursing home only if the person applies for the determination in accordance with the regulations.

"Determination respecting authorization

"(8.2) The placement coordinator designated for a nursing home under subsection (3) shall determine whether to authorize a person's admission to the nursing home only if the person applies for authorization of admission with respect to the nursing home in accordance with the regulations.

"Compliance with act and regulations

"(8.3) A placement coordinator shall make all determinations respecting eligibility for admission and all determinations respecting authorization of admission in accordance with this act and the regulations.

"Assessments etc to be taken into account

"(8.3.1) In making a determination respecting a person's eligibility for admission, a placement coordinator shall take into account any of the following which are provided to the placement coordinator:

"1. An assessment of the person made by a health practitioner relating to the person's impairment or capacity.

"2. An assessment or information relating to the person's requirements for medical treatment, health care or other personal care.

"Conditions of authorization

"(8.4) The placement coordinator designated for a nursing home under subsection (3) may authorize the admission of a person to the nursing home only if

"(a) the placement coordinator or another placement coordinator has determined, within the six months preceding authorization, that the person is eligible for admission to a nursing home;

"(b) the licensee of the nursing home to which the person's admission is to be authorized approves the person's admission to the nursing home; and

"(c)l the person consents to being admitted to the nursing home.

"Approval

"(8.5) A licensee of a nursing home shall approve a person's admission to the nursing home unless

"(a) the nursing home lacks the physical facilities necessary to meet the person's care requirements;

"(b) the staff of the nursing home lack the nursing expertise necessary to meet the person's care requirements; or "(c) circumstances exist which are prescribed by the regulations as being a ground for withholding approval.

"Written notice

"(8.6) A licensee who withholds approval for the admission of a person to a nursing home shall give to the person, the director and the placement coordinator designated for the nursing home under subsection (3) a written notice setting out the ground or grounds on which the licensee is withholding approval and a detailed explanation of the supporting facts.

"Alternative services

"(8.7) A placement coordinator shall suggest alternative services or make appropriate referrals on behalf of an application if

"(a) the placement coordinator determines that the applicant is not eligible for admission to a nursing home; or

"(b) the placement coordinator determines that the applicant is eligible for admission to a nursing home but does not authorize their immediate admission."

1150

Mr Jim Wilson: I'd just like to state that we'll be supporting this motion. I think it incorporates a number of the PC amendments that were put forward. It speaks to consumer choice, and in particular it speaks to the person's preferences, which I think are very important. It also incorporates, as was mentioned earlier, the previous PC motion, which was withdrawn because it is incorporated in this amendment, regarding the fact that people must be assessed in a six-month time frame and not left unassessed for longer than that period, if possible, on a waiting list. For those reasons and others, we're supportive of this amendment.

The Chair: Shall the government motion carry? Opposed? Carried.

Just before going back to the Liberal amendment to subsection 20.1(5.1), regarding the ongoing debate around "the" and "this," I am now informed that "the" should have been "this" and that "this" should not have been "the." So I am reopening section 25.

I'll get some guidance from the clerk. Do I need to read the offending paragraph or simply indicate that "the" has now become "this"? Perhaps, Ms O'Neill, seeing as this was a Liberal motion, you would move—the question is what. Does she need to read that?

Mrs O'Neill: Do you want me to go right through it again?

The Chair: Yes, probably the best thing would be to just read it again.

Mrs O'Neill: I move that subsection 4(2) of the Nursing Homes Act, as set out in section 25 of the bill, be struck out and the following substituted:

"Issuance of licence

"(2) No licensee shall operate a nursing home unless,

"(a) the licensee is a party to a service agreement with the crown in right of Ontario that relates to the home; and

"(b) the service agreement complies with this act and the regulations."

The Chair: Shall this motion carry? All in favour? Opposed? Carried.

Mr Jim Wilson: While we obviously agree with this, do you not need a motion to reopen the section?

The Chair: You're probably right.

Mr Jim Wilson: I think it takes unanimous consent to reopen a section.

The Chair: May I have unanimous consent to reopen

Mr Wessenger: Yes, unanimous consent is given.

The Chair: Thank you. There.

Mr Jim Wilson: I would just hate this bill not to pass because somebody was diligently reading his Hansard.

The Chair: It's a good thing you said "this."

Mr Wessenger: Do we have to repass the section then?

The Chair: We did it, so I think we're clear. Now we'll go forward to section 28, a Liberal amendment to subsection 20.1(5.1).

Mrs O'Neill: I think that particular amendment is included in the previous government amendment, so we'll not be placing it.

The Chair: It is not moved. Mr Wilson, subsection 20.1(6).

Mr Jim Wilson: I won't be placing this amendment, given that I've attempted twice before.

The Chair: It is not moved. Ms O'Neill, I believe.

Mrs O'Neill: We're in the same category; it seems the government suggests this is unnecessary.

The Chair: Again, Ms O'Neill with subsection 20.1(7).

Mrs O'Neill: Yes, I will be moving that.

The Chair: That is not moved.

Mrs O'Neill: I think I did want to move that.

The Chair: Oh, I'm sorry. You will move subsection 20.1(7)?

Mrs O'Neill: Yes.

The Chair: Please go ahead.

Mrs O'Neill: I move that subsection 20.1(7) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Determination regarding eligibility

"(7) A placement coordinator to whom application has been made in accordance with the regulations for a determination respecting a person's eligibility for admission to a nursing home shall, in accordance with the regulations, determine whether the person is eligible for admission and, if the placement coordinator determines that the person is eligible, determine a priority level for the person's admission."

As we were saying, as we've presented this previously, there does seem to be confusion around this issue, and this seems to be what the homes would find much more acceptable.

The Chair: Shall Ms O'Neill's motion carry? All those in favour? Opposed? Defeated.

Mr Wilson, 20.1(7.1).

Mr Jim Wilson: This has been incorporated to a large degree in the government's previous amendment and I will not move it.

The Chair: To the same part, Ms O'Neill?

Mrs O'Neill: I think I will read this in as well, 20.1. Is that the one we're at?

The Chair: We're at 20.1(7.1).

Mrs O'Neill: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Assessments etc to be taken into account

"(7.1) In making a determination respecting a person's eligibility for admission, a placement coordinator shall take into account any assessments made by a physician of the person relating to the person's impairment or capacity and any other assessments or information relating to the person's requirements for medical treatment, health care or personal care."

We've presented our reasons earlier.

The Chair: Shall Ms O'Neill's motion carry? All those in favour? Opposed? Defeated.

Conservative motion, Mr Wilson, 20,1(8).

Mr Jim Wilson: I move that subsection 20.1(8) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Priority and authorization

"(8) Subject to subsection (10), if the placement coordinator designated for a nursing home under subsection (3) receives an application, made in accordance with the regulations, for authorization of a person's admission to the home, the placement coordinator shall assign to the person a priority rating and, taking the priority rating into account, shall determine in accordance with the regulations whether to authorize the person's admission to the home.

"Assigning priority rating

"(8.1) The priority rating assigned to a person under subsection (8) shall be based on the immediacy of the need for admission of the other persons applying for admission.

"Priority rating for spouse

"(8.2) Despite subsection (8.1), a person applying for admission to a nursing home in which his or her spouse is resident shall be assigned, for the purposes of admission to the home, a priority rating that is higher than the priority rating assigned to the applicants for admission to the home who do not have spouses resident in the home.

"Priority rating for veteran

"(8.3) Despite subsections (8.1) and (8.2), a veteran applying for admission to a nursing home that receives or has received financial contributions from the Royal Canadian Legion shall be assigned, for the purposes of admission to such homes, a priority rating that is higher than the priority rating assigned to non-veterans applying for admission to such homes."

The intent of this amendment was to ensure that the government dealt with the issue regarding priority access for Canada's veterans where federal-provincial agreements are now in place. Secondly, it was an attempt to ensure that the government did not simply dismiss the spousal issue.

I would like a vote on it, although I will note in fairness that the government has moved, I think because both opposition parties forced it in this direction in previous

amendments and amendments to come, along the line of the principles indicated in this motion.

Mrs O'Neill: If I could clarify, our critic has had to leave, because, as you know, this meeting for today was called at very short notice. I too am going to leave very soon. I understood there had been an agreement that we would stack the votes from 12 to 12:30 until whatever happens at 2. Is that true?

The Chair: We can defer the votes.

Mrs O'Neill: I would like to do that on these issues, if we could.

The Chair: That's fine. We'll present them, discuss them, and we will simply defer the vote.

Mrs O'Neill: So beginning with this one or the next one I think would be more than satisfactory.

The Chair: Shall we vote on this one and then do that consequently?

Mrs O'Neill: That's fine.

1200

The Chair: With respect then to 20.1(8), shall Mr Wilson's motion carry? Opposed? Defeated.

It's 12 o'clock. We're going to go on until 12:30 and reconvene at 1:30, but from 12 to 12:30, whatever we get through, we'll defer the vote and from 1:30 to 2 we will defer the vote and then deal with those at 2 or shortly thereafter and then carry on.

Mr Wessenger: Unless we're all agreed.

The Chair: Unless we're all together, as they say.

I then have a Liberal amendment 20.1(8.1).

Mrs O'Neill: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Preferences and requirements of persons

"(8.1) In determining whether to authorize a person's admission to a nursing home, a placement coordinator shall take into account.

"(a) the person's ethnic, cultural, religious, linguistic and geographical preferences; and

"(b) the programs and services available at the nursing home that would help to meet the person's ethnic, cultural, religious, physical, linguistic and geographic requirements."

I've just read that in because we have not been successful in getting geographical preferences, but I'm not going to request a vote on that issue.

The Chair: Just so I'm clear then, the amendment 20.1(8.1) is—

Mrs O'Neill: It's been included in all the others except for geographic and we wanted to emphasize that.

The Chair: So it is removed?

Mrs O'Neill: Yes.

The Chair: Or not moved, I guess. Ms O'Neill, the next one is also yours.

Mrs O'Neill: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Limitation

"(8.2) A placement coordinator shall not authorize a person's admission to a nursing home unless the placement coordinator has determined that the care and services required for the person can be provided at the nursing home."

The Chair: Any discussion on that? If not, we'll defer the vote. Just for the record, I'll note that the previous Liberal amendment was withdrawn.

Mrs O'Neill: That's correct.

The Chair: Then Conservative amendment 20.1(8.4).

Mr Jim Wilson: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection after subsection (8.3):

"Alternative plan of care

"(8.4) A placement coordinator shall suggest an alternative plan of care to an applicant if,

"(a) the placement coordinator determines that the applicant is not eligible for admission to a nursing home; or

"(b) the placement coordinator determines that the applicant is eligible for admission to a nursing home but does not authorize their immediate admission."

Mr Wessenger: I think this is the one that's included, Mr Wilson, in one we already passed. It's one of the items that was included in (8.7).

Mr Jim Wilson: Which is exactly what I was going to ask you to say. I just want to ensure, Mr Wessenger, that the reason it is included is because there was a PC amendment on the table that the government saw fit to incorporate in its own amendment.

Of course the thrust of this amendment was to ensure that potential residents or applicants are simply not left in limbo and that the placement coordinator has an obligation to provide and to suggest, I think is the language in the amendment, alternative plans of care.

The Chair: So that is withdrawn?

Mr Jim Wilson: Withdrawn.

The Chair: We had dealt with 20.1(5) to (8.7), the government amendment, which was carried. We then have the Liberal amendment 20.1(9.1).

Mrs O'Neill: We feel this was a very important amendment on the veterans and their concerns. It has been included in government amendments now, so we will not be placing it.

The Chair: That is not moved. Now a subsequent Liberal amendment to 20.1(9.2).

Mrs O'Neill: I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.1:

"Information to home

"20.1.1 A placement coordinator who authorizes a person's admission to a nursing home shall, if the person consents, give to the licensee of the nursing home any of the following information that the placement coordinator has:

"1. Information about assessments of the person.

"2. Information about the person's social and personal care needs.

"3. The names and addresses of anyone who is authorized to make decisions for the person.

"4. Information about the person's medical history."

Mr Wessenger: We will be moving a motion that I believe incorporates that as well as other information. So I wonder if Ms O'Neill would either—

Mrs O'Neill: Why don't we stand it down? I had the feeling you were going to do that but I wanted to be sure.

The Chair: Sorry. I think, Ms O'Neill, you just read into the record your 20.1.1, but did you not have an amendment to 20.1(9.2), "Preference for persons discharged from facilities"?

Mrs O'Neill: Yes, I've got it here. Just to clarify, does what Mr Wessenger just said apply to what I read or does it apply to—

Mr Wessenger: It applied to what you read, not the other section

Mrs O'Neill: Okay, that's fine. What should we do then, just stand down the other thing that I read?

The Chair: In point of fact that would have been coming up next. So we'll defer that, do the government one, and then hopefully that will clarify everything. But let's now deal with this one, "Preference for persons discharged from facilities."

Mrs O'Neill: I'm sorry I am causing more confusion than necessary.

The Chair: No, that's quite all right.

Mrs O'Neill: I move that section 20.1 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Preference for persons discharged from facilities

"(9.2) In making determinations under this section, placement coordinators shall, subject to subsection (9.1), ensure that preference is given to persons whose discharge as a resident was authorized under section 20.3.2, section 9.7.2 of the Charitable Institutions Act or section 19.1.2 of the Homes for the Aged and Rest Homes Act."

The Chair: Okay, we'll defer the vote on that.

You have read into the record, Ms O'Neill, your motion 20.1.1. We have deferred that and we'll move on to the government amendment to the same section, 20.1.1.

Mr Wessenger: I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.1:

"Information to licensee

"20.1.1(1) A placement coordinator who authorizes a person's admission to a nursing home shall give to the licensee of the nursing home the information mentioned in a paragraph of subsection (2) if,

"(a) the placement coordinator has the information

mentioned in the paragraph; and

"(b) consent to the disclosure of the information to the licensee is given by,

"(i) the person whose admission is authorized; or

"(ii) the person, if any, who was lawfully authorized to consent to admission to the nursing home on behalf of the person whose admission is authorized.

"Same

- "(2) The information referred to in subsection (1) is the following:
- "1. Information about assessments of the person whose admission is authorized.
 - "2. Information about the person's medical history.
- "3. Information about the person's social and other care requirements.
- "4. The name and address of the person, if any, who was lawfully authorized to consent to admission to the nursing home on behalf of the person whose admission is authorized."

The Chair: Thank you.

Mrs O'Neill: I presume that's the one he was referring to, correct?

The Chair: Yes.

Mrs O'Neill: So we could withdraw.

The Chair: But we'll need to deal with the government motion first.

Mr Wessenger: I must say that we'll have to stand this one down because I'd like now to move, as we did with the other act, to substitute decisions resolutions.

The Chair: So we are deferring and then going to—

Mr Wessenger: Section 37.1 of the bill, section 39 of the Nursing Homes Act. That's the substitute decisions provision.

The Chair: So you will now deal with the substitute decision-making provision, 37.1, which is a new section.

Mr Wessenger: Yes.

The Chair: All right. Please go ahead.

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Mr Wessenger: I move that the bill be amended by adding the following section after section 37:

"37.1 The act is further amended by adding the following section:

"Transition

"39(1) This section applies until the Substitute Decisions Act, 1992 comes into force, and when the Substitute Decisions Act, 1992 comes into force, this section is repealed.

"Identifying person who is lawfully authorized

"(2) For the purposes of this act and the regulations, a person mentioned in a paragraph of subsection (3) is lawfully authorized to make a decision on behalf of another person concerning that person's personal care if,

"(a) the person on whose behalf the decision is to be made is apparently incapable of making the decision; and

"(b) the person mentioned in the paragraph is,

"(i) at least sixteen years old;

"(ii) available;

"(iii) apparently capable of making the decision; and

"(iv) willing to make the decision.

"Same

- "(3) For the purpose of subsection (2), the following persons may be lawfully authorized:
- "1. The apparently incapable person's committee of the person committed under the Mental Incompetency Act.
- "2. A spouse or partner of the apparently incapable person.

- "3. A child of the apparently incapable person.
- "4. A parent of the apparently incapable person.
- "5. A brother or sister of the apparently incapable person.
- "6. Another relative of the apparently incapable person.
- "Meaning of 'capable' and 'incapable'

"For the purpose of this section, a person is capable of making a decision if the person is able to understand the information that is relevant to making the decision and is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision, and a person is incapable of making a decision if the person is not capable of making the decision.

"Meaning of 'available'

"(5) For the purpose of this section, a person is available if it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a decision.

"Meaning of 'spouse'

- "(6) In this section, 'spouse' of an apparently incapable person means a person of the opposite sex,
- "(a) to whom the apparently incapable person is married; or
- "(b) with whom the apparently incapable person is living or was living immediately before being admitted to the nursing home, in a conjugal relationship outside marriage, if the two persons,
 - "(i) have cohabited for at least one year,
 - "(ii) are together the parents of a child, or
- $^{\prime\prime\prime}(iii)$ have together entered into a cohabitation agreement under section 53 of the Family Law Act.

"Meaning of 'partner'

"(7) Two persons are partners for the purpose of this section if they have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives.

"Ranking

"(8) A person mentioned in a paragraph of subsection (3) is not lawfully authorized to make a decision if a person mentioned in an earlier paragraph of section 3 is lawfully authorized to make it.

"Same

"(9) If two or more persons mentioned in the same paragraph of subsection (3) would be lawfully authorized to make the decision, they shall select one person from among them, and the person selected is the only one of them who is lawfully authorized to make the decision.

"Decisions on person's behalf

- "(10) A person who makes a decision on behalf of an apparently incapable person shall do so in accordance with the following principles:
- "1. If the person knows of a wish that the apparently incapable person expressed while capable, the person shall make the decision in accordance with the wish.
- "2. If the person does not know of a wish that the apparently incapable person expressed while capable, the person shall make the decision in the apparently incapable person's best interests.

"Best interests

"(11) In deciding what an apparently incapable person's best interests are, the person making the decision shall take into consideration.

"(a) the values and beliefs that the person knows the apparently incapable person held when capable and believes the apparently incapable person would still act on if capable; and

"(b) the apparently incapable person's current wishes, if they can be ascertained."

We'll defer the vote

Mr Jim Wilson: Just in case I don't have the time when we actually vote on this, I want to indicate that we will not be supporting this amendment, as was the case the previous two times that it was presented, because we do not feel that it really lives up fully to the intent of the Substitute Decisions Act and that the interim measures simply aren't well enough thought out.

The Chair: We'll then go back to government motion 20.1.2, because we are deferring the vote on 20.1.1.

Mr Wessenger: We'll have to defer the vote on this too, I think.

The Chair: Yes, but it needs to be presented.

Mr Wessenger: Oh, 20-

The Chair: Section 20.1.2. I believe I'm right. You have moved 20.1.1.

Mr Wessenger: Yes.

The Chair: We have deferred the vote on that, so we're now going to your motion 20.1.2.

Mr Wessenger: Oh, this one. Okay, thank you. I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act, after section 20.1.1:

"Preference for veterans

"20.1.2 The minister shall ensure that preference is given to veterans for access to beds that,

"(a) are located in nursing homes for which funding is provided under an agreement between the government of Ontario and the government of Canada relating to veterans; and

"(b) are designated by the minister as veterans' priority access beds."

The Chair: Then we will defer the vote on that.

Mr Wessenger: It may be that this is—I'm wondering—

The Chair: I think we need to defer the votes because we agreed to do that.

Mr Wessenger: Okay.

The Chair: Then government motion 20.2.

Mr Wessenger: I move that section 20.2 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by:

(i) striking out "a placement coordinator or a member" in the second and third lines and substituting "an"; and

(ii) adding the following subsection:

"Placement coordinator's liability

"(2) Subsection (1) does not relieve a placement coordinator of liability for the acts or omissions of its employees or agents."

Again, vote deferred.

The Chair: Then Mrs Fawcett, Liberal motion 20.1.1. Sorry, 20.2.1.

Mr Wessenger: No, I have 20.1.1. Oh, that was withdrawn.

The Chair: Excuse me. Just on that point, there's some confusion with respect to the Liberal motion 20.1.1 as to whether it was withdrawn or deferred. I thought it had been withdrawn but it's been indicated at the table that it's still—

Mrs Joan M. Fawcett (Northumberland): Ms O'Neill withdrew that.

The Chair: I thought she had as well. I think, then, with your concurrence, Ms Fawcett, we'll just note that the Liberal amendment 20.1.1 has been withdrawn.

Now, Ms Fawcett, Liberal amendment 20,2,1.

Mrs Fawcett: I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.2:

"Notice of determination to licensee.

"20.2.1(1) A placement coordinator who determines that a person's admission to a nursing home should be authorized shall serve a notice of the determination on the licensee of the nursing home.

"Application provisions

"(2) Subsections 20.3(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (1).

"Hearing by appeal board

"(3) A licensee that is served with a notice of determination is entitled to a hearing by the appeal board if the licensee mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(4) Subsections 20.4(1), (2) and (5) apply, with necessary modifications, with respect to a hearing required by a licensee under subsection (3).

"Powers of appeal board

"(5) After a hearing by the appeal board, the appeal board may,

"(a) affirm the determination made by the placement coordinator;

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator not to authorize the person's admission to the nursing home."

Vote deferred?

The Chair: That will be deferred. Government amendment 20.3.

Mr Wessenger: I move that section 20.3 of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Notice of determination

"20.3(1) If a placement coordinator determines that an applicant for a determination respecting eligibility for admission to a nursing home is not eligible, the placement coordinator shall ensure that the applicant and the person, if any, who applied for the determination on behalf of the applicant are notified of,

"(a) the determination of ineligibility;

"(b) the reasons for the determination; and

"(c) the applicant's right to apply to the appeal board for a review of the determination.

"Application to appeal board

"(2) The applicant may apply to the appeal board for a review of the determination of ineligibility made by the placement coordinator."

Vote deferred.

The Chair: Deferred.

Liberal amendment 20.3(1), (2.1), (3), (4), (5), (7), Ms Fawcett?

Mr Wessenger: I have a 20.3.

Interjections.

The Chair: Now wait. I guess this is a new one. The order here is sometimes different. I'm not quite sure—I think as we're just reading these in at the present time, why don't you go ahead with what I suggested.

1220

Mr Jim Wilson: There is a section 20.3, Liberal.

The Chair: Okay, do section 20.3.

Mrs Fawcett: I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.3:

"Notice of determination to person seeking admission

"20.3.1(1) A placement coordinator who determines that a person's admission to a nursing home should not be authorized shall serve a notice of the determination on the person.

"Applicable provisions

"(2) Subsections 20.3(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (1).

"Hearing by appeal board

"(3) A person who is served with a notice of determination is entitled to a hearing by the appeal board if the person mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(4) Subsections 20.4(1), (2) and (5) apply, with necessary modifications, with respect to a hearing requested by a person under subsection (3).

"Powers of appeal board

"(5) After a hearing by the appeal board, the appeal oard may,

"(a) affirm the determination made by the placement coordinator;

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the person's admission to the nursing home"

The Chair: The vote will be deferred. There is also a section 20.3 Conservative motion, so let us put that next on the record and then we'll do this.

Mr Jim Wilson: I won't introduce this amendment. It was an attempt once again to legislate a priority rating system and to change a bit of the language.

The Chair: That was section 20.3 and that is not moved. I'll then go to Mrs Fawcett to do the longer one with all the parts. It's subsections 20.3(1), (2.1), (3), (4), (5) and (7). It's a one-page motion.

Mrs Fawcett: Yes, I have that now. Thank you.

I move that subsection 20.3(1) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Notice of determination

"(1) A placement coordinator who makes a determination whether an applicant is eligible for admission to a nursing home shall serve on the applicant a notice of determination."

I further move that section 20.3 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection:

"Contents of notice

"(2.1) A notice of determination of eligibility under subsection (1) shall inform the applicant of,

"(a) the priority level for the person's admission;

"(b) the requirements set out in subsection (5) for entitlement to a hearing by the appeal board; and

"(c) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing."

I further move that subsections 20.3(3), (4), (5) and (7) of the Nursing Homes Act, as set out in section 28 of the bill, be amended by striking out "determination of ineligibility" everywhere it appears and substituting "determination."

The Chair: The vote is deferred. Mr Wilson, section 20.3.1.

Mr Jim Wilson: I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.3:

"Discharge for transfer

"20.3.1(1) The licensee of a nursing home may apply, in accordance with the regulations, to the placement coordinator designated for the nursing home for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the nursing home.

"Determination

"(2) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the nursing home.

"Authorization

"(3) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the applicant on an appropriate alternative setting for the resident.

"Discharge

"(4) An applicant may discharge a resident of a nursing home when so authorized by a placement coordinator.

"Notice of determination

"(5) The placement coordinator shall serve a notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the nursing home and determines not to authorize the resident's discharge, and subsections 20.3(2) to (7) apply with necessary modifications."

The Chair: Thank you. We'll defer that.

Ms Fawcett, 20.3.1 and 20.3.3. That is a yellow Liberal motion.

Mrs Fawcett: I don't have that.

The Chair: By colour only: 20.3.2 and 20.3.3.

Mrs Fawcett: Okay.

The Chair: This will be the last one we'll deal with before the break.

Mrs Fawcett: I move that section 28 of the bill be amended by adding the following sections to the Nursing Homes Act, after section 20.3.1:

"Discharge for transfer

"20.3.2(1) A licensee of a nursing home may apply, in accordance with the regulations, to the placement coordinator designated for the home for authorization to discharge a resident for transfer to an appropriate alternative setting if the care requirements of the resident cannot be met in the home.

"Notice to resident

"(2) The applicant shall give notice of the application to the resident.

"Determination

"(3) The placement coordinator to whom an application under subsection (1) is made shall determine whether the resident's care requirements can be met in the home.

"Authorization

"(4) If the placement coordinator determines that the care requirements cannot be met, the placement coordinator shall authorize the applicant to discharge the resident and shall advise the resident on an appropriate alternative setting for the resident.

"Discharge

"(5) An applicant may discharge a resident of a nursing home when so authorized by a placement coordinator if an appropriate alternative setting for the resident is available and transfer to that setting is consented to by the resident or a person authorized to consent on behalf of the resident.

"Notice of determination

"(6) The placement coordinator shall serve a notice on the applicant if the placement coordinator determines that the resident's care requirements can be met in the home and determines not to authorize the resident's discharge.

"Applicable provisions

"(7) Subsections 20.3(2), (3), (4) and (6) apply, with necessary modifications, with respect to a notice of determination under subsection (6).

"Hearing by an appeal board (discharge)

"20.3.3(1) A licensee of a nursing home who is served with a notice of determination under subsection 20.3.2(6) is entitled to a hearing by the appeal board if the licensee mails or delivers to the placement coordinator and to the appeal board, within thirty days after the notice of determination is served, a notice requiring a hearing.

"Applicable provisions

"(2) Subsections 20.4(1) and (2), 14(3) and 20.4(5) apply, with necessary modifications, with respect to a hearing required by a licensee under subsection (1).

"Powers of appeal board

"(3) After a hearing by the appeal board, the appeal oard may,

"(a) affirm the determination made by the placement coordinator;

"(b) rescind the determination made by the placement coordinator and refer the matter back to the placement coordinator for redetermination in accordance with such directions as the appeal board considers proper; or

"(c) rescind the determination made by the placement coordinator, substitute its opinion for the opinion of the placement coordinator and direct the placement coordinator to authorize the resident's discharge."

The Chair: Thank you. Just before we break, because I had down two amendments, 20.3.1 and 20.3.3, I just want to note that what you read was 20.3.2 and 20.3.3. Is that correct? That is what is on your sheet?

Mrs Fawcett: Yes.

The Chair: That's right, so if anyone had another one, it doesn't exist—

Mrs Fawcett: Okay. Actually, I had that here but I didn't read the right number.

The Chair: —except in my head. So that vote will be deferred.

At this point, then, we will recess until 1:30.

The committee recessed at 1229.

AFTERNOON SITTING

The committee resumed at 1331.

The Chair: Good afternoon. We begin the afternoon session. We are at government amendment 20.4(1) and (2).

Mr Wessenger: I move that subsections 20.4(1) and (2) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Hearing

"20.4(1) When the appeal board receives an application for a review of a determination of ineligibility, it shall promptly appoint a time and place for a hearing.

"Same

"(2) The hearing shall begin within twenty-one days after the day the appeal board receives the application for the hearing, unless the parties agree to a postponement.

"Notice to parties

"(2.1) The appeal board shall notify each of the parties of the time and place of the hearing at least seven days before the hearing begins.

"Parties

"(2.2) The parties to the proceeding before the appeal board are the applicant who was determined to be ineligible for admission, the placement coordinator who made the determination and such other parties as the appeal board specifies.

"Notice to minister

"(2.3) When a placement coordinator is notified by the appeal board of a hearing, the placement coordinator shall promptly give the minister written notice of the hearing together with written reasons for the determination of ineligibility made by the placement coordinator.

"Minister entitled to be heard

"(2.4) The minister is entitled to be heard by counsel or otherwise in a proceeding before the appeal board under this section."

The Chair: We'll defer the vote on that motion. Mr Wilson, 20.4(1.1).

Mr Jim Wilson: I will not be introducing this, given that the government's motion that was just read sets the time frame for 21 days versus 90 days.

The Chair: Not moved. We will then move to government motion 20.4(3).

Mr Wessenger: I move that subsection 20.4(3) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Quorum of appeal board

"(3) Three members of the appeal board constitute a quorum and are sufficient for the exercise of the jurisdiction and powers of the appeal board under this act."

The Chair: We'll defer the vote on that and move to 20.4(4).

Mr Wessenger: I move that subsection 20.4(4) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out.

Vote deferred on that, please.

The Chair: Just one second. That was 20.4(4).

Mr Wessenger: I think we can have the PC one withdrawn; it's exactly the same, and the Liberal one is exactly the same.

Mr Jim Wilson: Since the PC motion is exactly the same, we'll withdraw it, or not introduce it.

The Chair: So that is the Conservative motion 20.4(4), and the same for the—

Mrs Fawcett: For the Liberal motion 20.4(4).

The Chair: I also have a Liberal motion 20.4(3) and (6).

Mrs Fawcett: Is that included in what the government read or is that different?

The Chair: Does that relate to the government motion? Perhaps Mr Wessenger and Mr Wilson could—

Mrs Fawcett: I don't have a copy of the government motion, unfortunately.

The Chair: I think perhaps we'd better read it in and then we'll deal with that.

Mrs Fawcett: I move that subsections 20.4(3) and (6) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out. And defer.

The Chair: That would be deferred.

Mr Wessenger: I think it may be covered, but we can deal with that later.

The Chair: Then we are at government motion 20.4(5.1) to (5.4).

Mr Wessenger: I move that section 20.4 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsections after subsection (5):

"Evidence of disabled person

"(5.1) If a party to a proceeding before the appeal board under this act wishes to give evidence in the proceeding or wishes to call another person as a witness to give evidence in the proceeding but the party or other person is unable to attend the hearing by reason of age, infirmity or physical disability, the appeal board members holding the hearing may, at the request of the party, attend upon the party or the other person, as the case may be, and take his or her evidence.

"Medical report proves inability

"(5.2) A medical report signed by a legally qualified medical practitioner stating that the practitioner believes that the person is unable to attend the hearing by reason of age, infirmity or physical disability is proof, in the absence of evidence to the contrary, of the inability of the person to attend the hearing.

"Opportunity for all parties

"(5.3) No appeal board member shall take evidence from a party or other person under subsection (5.1) unless reasonable notice of the time and place for taking the evidence is given to all parties to the proceeding and each party attending is given an opportunity to examine or cross-examine the party or other person, as the case may be.

"Recording of evidence

"(5.4) The oral evidence taken before the appeal board at a hearing and the oral evidence taken from a party or other person under subsection (5.1) shall be recorded and, if required, copies of a transcript of the evidence shall be furnished on the same terms as in the Ontario Court (General Division)."

Vote deferred.

The Chair: Deferred.

Then the government motion 20.4(6).

Mr Wessenger: I move that subsection 20.4(6) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Health Insurance Act

"(6) Subsections 23(1), (2), (4), (5) and (6) of the Health Insurance Act apply to the proceedings and decisions of the appeal board under this act."

The Chair: That will also be deferred. We then have Conservative motions.

Mr Jim Wilson: Both Conservative motions dealing with subsection 20.4(7) will not be introduced. Since the government hasn't agreed to previous amendments, these would no longer make sense.

The Chair: Thank you, Mr Wilson. So those two motions are not moved. Then we go to government motion 20.4(7.1).

Mr Wessenger: I move that section 20.4 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsection after subsection (7):

"Decision and reasons

"(7.1) The appeal board shall render its decision within one day after the end of the hearing and shall provide written reasons to the parties within seven days after rendering the decision."

Vote deferred.

The Chair: Deferred, Mr Wilson, 20.4.1.

Mr Jim Wilson: Again, Mr Chairman, this amendment wouldn't make sense in light of previous amendments having been voted down, so I will not introduce it.

The Chair: This is not being moved. You have a subsequent amendment 20.6(3) to (5).

Mr Jim Wilson: I'm in the process of determining whether that still makes sense, Mr Chairman.

The Chair: We can pause a while.

Mr Jim Wilson: It really doesn't, so it won't be introduced.

The Chair: Not moved. This takes us to government motion 20.8.

Mr Wessenger: I move that section 20.8 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by striking out "and" at the end of clause (c) and by adding the following clause after clause (c):

"(c.1) an opportunity to participate fully in the development and revision of the resident's plan of care is provided to the resident, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct:"

The Chair: We'll defer that.

Then Liberal amendment 20.8(d).

Mrs Fawcett: I move that clause 20.8(d) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out

The Chair: There are three amendments, two that follow on the same section, Ms Fawcett.

Mr Wessenger: If I might assist Ms Fawcett-

Mrs Fawcett: All right, would you please.

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Mr Wessenger: The ones previous: One was withdrawn. That was the one relating to the second, which was four lines, and the one moved by Miss Sullivan was the one with five lines, so I suggest you might not move the—

The Chair: So the one that was just moved.

Mr Wessenger: Yes.

The Chair: Okay. The second one was withdrawn—

Mr Wessenger: Yes.

The Chair: —and the third one was moved, or not moved.

Mr Wessenger: The third one was moved, the second one was not moved.

The Chair: Right.

Mrs Fawcett: The second one was not moved.

The Chair: But the third one, with the five lines—if you would move that.

Mrs Fawcett: I move that clause 20.8(d) of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"(d) the care outlined in the plan of care, for which the licensee is responsible for providing under the service agreement or a contract between the licensee and the resident, and for which the licensee has been compensated, is provided to the resident."

Mr Jim Wilson: Mr Chairman, the first Liberal clause 20.8(d), was that withdrawn? That's the one to strike out the clause.

The Chair: Yes.

Mr Jim Wilson: Right, it's redundant. It was dropped.

Mrs Fawcett: What would I do, just withdraw it?

The Chair: Yes, if you want to withdraw it.

Mrs Fawcett: I withdraw it now that I see what it's-

The Chair: Okay, so the first one is withdrawn; the second one not moved; the third one has been presented. The Chair appreciates the advice and cooperation of members and please feel free to continue.

Subsections 20.8(2) and (3), that's a Liberal amendment.

Mrs Fawcett: I move that section 20.8 of the Nursing Homes Act, as set out in section 28 of the bill, be amended by adding the following subsections:

"Resident's participation in developing plan

"(2) A plan of care for a resident shall not be developed or revised without the participation of the resident or another person authorized to act on the resident's behalf.

"Resident's consent in implementing plan

"(3) A plan of care for a resident shall not be implemented without the consent of the resident or another person authorized to consent on the resident's behalf."

Mr Wessenger: That is partially covered.

Mrs Fawcett: That is partially covered. As I was reading it I realized that.

The Chair: We'll defer on that one.

Mr Hope: Just before you move on, there were two 20.8(d)s for the Liberals and was there one that—both of them got deferred over—

The Chair: There were three of them: the first one withdrawn, the second one not moved and the third one is moved.

Mr Hope: It's deferred, okay.

The Chair: It'll be deferred. Then the one we just did is deferred and then we go to section 20.8.1, which is the one entitled "Immunity for employees." Do you have that, section 20.8.1?

Mrs Fawcett: Section 20.8.1, right.

I move that section 28 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.8:

"Immunity for employees

"20.8.1 No proceeding for damages shall be commenced against an employee of a nursing home for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in good faith of the person's duty."

The Chair: That will be deferred and we then go to section 20.9.

 \mbox{Mr} Wessenger: I move that section 20.9 of the Nursing—

The Chair: Sorry, it's a Liberal—

Mr Wessenger: There are two motions.

The Chair: I think yours is—oh, I'm sorry. I don't show it on my list.

Mrs Fawcett: There is a government 20.9 and then the Liberal 20.9.

The Chair: Okay. Let's do the government one first and then we'll do the Liberal one.

Mr Wessenger: They may wish to withdraw it.

The Chair: It gives Miss Fawcett a break.

Mr Wessenger: I move that section 20.9 of the Nursing Homes Act, as set out in section 28 of the bill, be struck out and the following substituted:

"Quality management

"20.9 A licensee of a nursing home shall ensure that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the nursing home."

The Chair: That will be deferred. Now, if we go back to the Liberal motion—

Mrs Fawcett: It appears to be covered in the government motion. I'm glad the government took our advice.

The Chair: So the Liberal 20.9 is not moved and we go to the Conservative amendment.

Mr Jim Wilson: Mr Chairman, given that the government did indeed take the opposition's advice with regard to quality management, it's not necessary to introduce this amendment.

The Chair: Okay, it's not moved.

Mr Wilson, 20,9(2).

Mr Jim Wilson: C'est la même chose, Monsieur.

The Chair: Merci beaucoup. Not moved.

Conservative amendment, 20.10.

Mr Jim Wilson: I won't be moving that amendment, Mr Chairman. I'll be defeated on that one.

The Chair: Not moved.

That completes all of the parts of section 28, so we will come back on the deferred votes as well as having to deal with this section in its entirety.

We'll now go on to section 29, beginning with Mrs Fawcett. Section 29, 20.11(1.1), if that is handy.

Mrs Fawcett: I move that section 20.11 of the Nursing Homes Act, as set out in section 29 of the bill, be amended by adding the following subsection:

"Payments must be sufficient

"(1.1) The payments under subsection (1) must be in such amounts that the payments, together with any amounts for which residents are responsible, are sufficient to defray all the costs described in subsection (1)."

The Chair: Mrs Fawcett, I regret, but that is out of order under section 56 of the standing orders.

Mrs Fawcett: A pity, Mr Chairman.

The Chair: We move to the next Liberal amendment, which is 20.11(2).

Mrs Fawcett: I move that subsection 20.11(2) of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"Service agreement

"(2) No payment shall be made under subsection (1) unless,

"(a) the licensee receiving the payment is a party to a service agreement with the crown in right of Ontario that relates to the nursing home; and

"(b) the service agreement complies with this act and the regulations."

The Chair: And that will be deferred. Government amendment, Mr Wessenger.

Mr Wessenger: I move that subsection 20.11(3) of the Nursing Homes Act, as set out in section 29 of the bill, be amended by striking out "is in breach of his, her or its" in the second and third lines and substituting "has breached the".

Mr Jim Wilson: Mr Chairman, we'll be opposing this amendment when the time comes to vote.

The Chair: You have the next amendment, Mr Wilson 20.11.1 and 20.11.2.

Mr Jim Wilson: With the committee's indulgence, I'd like to proceed with this amendment.

I move that section 29 of the bill be amended by adding the following sections to the Nursing Homes Act, after section 20.11:

"Notice before reduction or withholding

"20.11.1(1) Before reducing or withholding a payment to a licensee under subsection 20.11(3), the minister shall serve on the licensee a notice setting out

"(a) the minister's proposal to reduce or withhold a payment under subsection 20.11(3):

"(b) the proposed amount of the reduction or the amount proposed to be withheld, as the case may be:

"(c) the breach or breaches of the service agreement on which the minister relies for reducing or withholding payment:

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board:

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the licensee at the licensee's most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) A licensee who is served with a notice under subsection (1) is entitled to a hearing by the appeal board if the licensee mails or delivers to the minister and to the appeal board, within 30 days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If the licensee does not require a hearing in accordance with subsection (4), the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) The licensee may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal hoard

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for the extension; and

"(b) may give such directions as it considers proper in light of the extension.

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"Hearing

"(7) If the licensee requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

"(9) The parties to a proceeding before the appeal board under this section are the licensee, the minister and such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 20.4(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section.

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal;

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to make a reduction or withholding under subsection 20.11(3) in such lower amount:

"(b) may, if the minister has carried out the proposal under subsection (5).

"(i) find that the proposal was reasonable in the circumstances:

"(ii) direct the minister to pay to the licensee the amount of the reduction or the amount withheld, as the case may be: or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the licensee the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable;

"(c) may substitute its opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on appeal

"20.11.2 On an appeal to the Divisional Court from a decision of the appeal board under section 20.11.1, the Divisional Court,

"(a) may affirm or rescind the decision of the appeal board;

"(b) may substitute its opinion for that of the minister or the appeal board; and

"(c) may exercise all the powers of the appeal board."

My previous comments stand with respect to this issue.

The Chair: We'll defer that. Ms Fawcett, 20.12.1.

Mrs Fawcett: Federal funding for veterans: I believe that has been covered.

The Chair: This motion in and of itself would be out of order.

Mrs Fawcett: We certainly realize it's a very important part that should be included.

The Chair: And it has been. Then Conservative motion 20.13(1)(a).

Mr Jim Wilson: I move that clause 20.13.(1)(a) of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"(a) shall provide that it continues in full force and effect until replaced or cancelled in accordance with the regulations:

"(a.1) shall contain a dispute resolution mechanism for resolving disputes related to the service agreement;

"(a.2) shall provide for a right to arbitration if the dispute resolution mechanism fails to resolve a dispute;

"(a.3) shall contain the other provisions required by the regulations to be contained in a service agreement."

The Chair: That'll be deferred. Next, 20.13(1)(c), which is also yours, Mr Wilson.

Mr Jim Wilson: I move that clause 20.13.(1)(c) of the Nursing Homes Act, as set out in section 29 of the bill, be amended by adding after "(a)" in the last line, "(a.1), (a.2) or (a.3)".

The Chair: Deferred. A Liberal amendment 20.13.1, term of service agreement.

Mrs Fawcett: I move that section 29 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.13:

"Term of service agreement

"20.13.1(1) Each service agreement shall be for a one year term.

"If no new service agreement

"(2) If a new service agreement is not entered into before the expiry of the current service agreement the following provisions apply:

"1. Despite subsection (1), the current service agreement continues in force until a new service agreement is entered into or until the current service agreement is terminated.

- "2. Any new service agreement that is entered into shall be deemed to have been in force since the current service agreement would have, but for paragraph 1, ceased to be in force.
- "3. Interest shall be paid on all unpaid amounts that, under the new service agreement, should have been paid during the time the new service agreement is deemed to have been in force."

The Chair: Mrs Fawcett, I'll have to rule this motion out of order under section 56, the third clause, dealing with payments.

Mrs Fawcett: Thank you, Mr Chairman. It is a pity.

The Chair: So the Liberal motion, section 20.13.1, is out of order. We then move to the Conservative motion, section 20.13.1.

Mr Jim Wilson: I move that section 29 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.13:

"Arbitration

"20.13.1(1) This section applies with respect to arbitrations under a service agreement.

"Notice

"(2) An arbitration is commenced by a party to a service agreement giving written notice to the other party of its desire to arbitrate a dispute related to the serviceagreement.

"Appointment of board of arbitration

"(3) Within fourteen days of the written notice having been given, the parties,

"(a) shall jointly appoint a member of the appeal board to sit as a board of arbitration; or

"(b) shall each appoint a person to sit on the board of arbitration.

"Same

"(4) If the parties each appoint a person to sit on the board of arbitration, the two persons so selected shall, within ten days after the second of the persons has been appointed, appoint a member of the appeal board.

"Powers of the board of arbitration

"(5) The board of arbitration shall hold a hearing to examine and decide the matters that are in dispute between the parties.

"Service agreements

"(6) Any decision of the board of arbitration shall form part of the service agreement.

"Costs

"(7) The board of arbitration may award costs.

"Appeal to Divisional Court

"(8) A party may appeal a decision of the board of arbitration to the Divisional Court on a question of law or fact or both.

"Powers of court on appeal

"(9) On an appeal to the Divisional Court from a decision of the board of arbitration under this section, the Divisional Court may do any one or more of the following:

"1. Affirm or rescind the decision of the board of arbitration.

"2. Substitute its opinion for that of the board of arbitration.

"3. Exercise any power of the board of arbitration."

The Chair: We will defer that.

Liberal amendment, section 20.13.2.

Mrs Fawcett: I move that section 29 of the bill be amended by adding the following section to the Nursing Homes Act after section 20.13.1:

"Arbitration where failure to negotiate service agreements

"20.13.2(1) A licensee of a nursing home may require an arbitration by the appeal board by giving notice in accordance with subsection (2) if there has been a failure to successfully negotiate,

"(a) an initial service agreement;

"(b) a subsequent service agreement; or

"(c) amendments to a service agreement in response to changing circumstances.

"Notice requiring arbitration

"(2) To require an arbitration, a notice requiring an arbitration must be mailed or delivered to the minister and to the appeal board.

"Arbitration

"(3) If the appeal board receives a notice under subsection (2), the appeal board shall arbitrate the matter in dispute. "Parties

"(4) The parties to an arbitration are the person requiring the arbitration and the minister.

"Applicable provisions

"(5) Subsections 14(3) and 20.4(5) apply, with necessary modifications, with respect to an arbitration.

"Powers of appeal board

"(6) In arbitrating the matters in dispute, the appeal board may order the minister,

"(a) to sign on behalf of the crown in right of Ontario a service agreement with such terms as the appeal board specifies; or

"(b) to sign on behalf of the crown in right of Ontario an agreement that amends an existing service agreement in such manner as the appeal board specifies."

The Chair: We'll defer the vote on that and go to the Conservative motion, clause 20.14(1)(a).

Mr Jim Wilson: I move that clause 20.14(1)(a) of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"(a) the rights and obligations of the resident and of the licensee."

Again, this is just recognizing that the institutions have rights, as do residents.

1400

The Chair: Deferred, and then government motion 20.14.

Mr Wessenger: I move that section 20.14 of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"Notice to residents

"20.14(1) A licensee of a nursing home shall give to each resident of the nursing home, to the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care and to such other person as they may direct, a written notice,

"(a) setting out the rights of the resident under subsection 2(2) and stating that the licensee is obliged to

respect and promote those rights;

"(b) describing the accommodation, care, services, programs and goods that the licensee is required to provide or offer under this act and under the service agreement relating to the nursing home;

"(c) stating that the resident, the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care or such other person as they may direct may request access to and an explanation of the resident's plan of care, and specifying the person to whom such a request must be made;

"(d) setting out the procedures for making complaints about the maintenance or operation of the nursing home, the conduct of the staff of the nursing home or the treatment or care received by the resident in the nursing home; and

"(e) setting out such other matters as are prescribed by the regulations.

"Obligations re plan of care

"(2) If a request is made in accordance with clause (1)(c), the licensee shall ensure that access to and an

explanation of the plan of care is provided to the person who made the request."

The Chair: That will be deferred. Government motion 20.15

Mr Wessenger: I move that section 20.15 of the Nursing Homes Act, as set out in section 29 of the bill, be amended by:

(i) renumbering clause (a) as clause (a.1) and adding the following clause:

"(a) a copy of section 2;" and

(ii) adding the following clause after clause (a.1):

"(a.2) a copy of the most recent inspection report relating to the home received by the licensee under subsection 24(13)."

The Chair: That will be deferred. We have another government motion, 20.15(2).

Mr Wessenger: I move that subsection 20.15 of the Nursing Homes Act, as set out in section 29 of the bill, be amended by adding the following subsection:

"Exception

"(2) In posting anything under subsection (1), the licensee shall not disclose the salary of an individual."

The Chair: That will be deferred. Then a Liberal motion 20.15

Mrs Fawcett: I move that section 20.15 of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"Availability of information

"20.15 A licensee of a nursing home shall ensure that the following documents are made available in a prominent place in the home:

"1. A copy of the service agreement relating to the home.

"2. Copies of those financial statements, reports and returns filed with the minister that the regulations require to be made available.

"3. All other documents and information that the regulations require to be made available."

The Chair: That will be deferred. We then have a Conservative motion 20.15.

Mr Jim Wilson: I move that section 20.15 of the Nursing Homes Act, as set out in section 29 of the bill, be struck out and the following substituted:

"Having documents available

"20.15(1) A licensee of a nursing home shall ensure that the following documents are available for inspection in the home:

"1. A copy of the service agreement relating to the home.

"2. A copy of each of the financial statements, reports and returns that the licensee has filed with the minister under this act.

"3. All other documents that the regulations require the licensee to have available for inspection in the home.

"Notice to residents

"(2) The licensee shall post a notice in the home informing residents how they can inspect the documents referred to in subsection (1)."

The Chair: That will be deferred.

That completes the amendments in section 29. We will then, however, go on with section 30, because there are a couple under section 29 where there may be a recorded vote, so we'll continue with section 30. We have a series of government amendments we will deal with first. Mr Wessenger, I think there are four there, beginning with 21(1)(a).

Mr Wessenger: I move that clause 21(1)(a) of the Nursing Homes Act, as set out in section 30 of the bill, be amended by striking out "for basic accommodation" in the first line and substituting "for a class of basic accommodation."

The Chair: And 21(1)(e)?

Mr Wessenger: I move that clause 21(1)(e) of the Nursing Homes Act, as set out in section 30 of the bill, be struck out and the following substituted:

"(e) for care, services, programs or goods that are not mentioned in clause (a), (b), (c), (d) or (2)(a) and in respect of which the resident has entered into a written agreement with the licensee, the amount determined in accordance with the written agreement."

The Chair: Thank you. Deferred. Clause 21(2)(b).

Mr Wessenger: I move that clause 21(2)(b) of the Nursing Homes Act, as set out in section 30 of the bill, be amended by striking out "or on behalf of" in the fifth line.

The Chair: Thank you. Deferred. Government amendment 21.1.

Mr Wessenger: This will not be moved.

The Chair: Okay, not moved. Then we go to Liberal amendment under 30.1, 21.1. That's a new one.

Mrs Fawcett: I don't have any of those.

The Chair: Okay, that's 30.1.

Mrs Fawcett: I move that the bill be amended by adding the following section:

"30.1 The act is amended by adding the following section:

"Resident responsible for payments for accommodation

"21.1(1) A resident is responsible for the payment of those amounts demanded by a licensee for accommodation in accordance with section 21.

"Minister to give statements

"(2) The minister shall provide, annually and on the request of a resident, a statement setting out how much the resident may be charged for accommodation under subsection 21(1)."

The Chair: Thank you. I then have a Conservative motion to section 31 of the bill on section 22.

Mr Jim Wilson: I move that section 22 of the Nursing Homes Act, as set out in section 31 of the bill, be amended by adding the following subsection after subsection (1):

"No recovery of charge

"(1.1) No deduction shall be made under subsection (1) unless written notice about the fact that the item paid for has not been provided or made available to the resident is given to the minister within 90 days after the date on which the person from whom the licensee accepted payment discovers the fact."

The Chair: Thank you. That will be deferred. You have a further amendment to this section?

Mr Jim Wilson: I move that section 22 of the Nursing Homes Act, as set out in section 31 of the bill, be amended by adding the following subsection after subsection (2):

"No recovery of charge

"(2.1) No deduction shall be made under subsection (2) unless written notice about the fact that the payment exceeds the amount permitted to be charged under section 21 is given to the minister within ninety days after the date on which the person from whom the licensee accepted payment discovers the fact."

The Chair: Thank you. Vote deferred. A final amendment to 22.

Mr Jim Wilson: I move that section 22 of the Nursing Homes Act, as set out in section 31 of the bill, be amended by adding the following subsection after subsection (3):

"No recovery of charge

"(3.1) No deduction shall be made under subsection (3) unless written notice about the fact that the item paid for has been inadequately provided is given to the minister within ninety days after the date on which the person from whom the approved corporation accepted payment discovers the fact."

I wonder if the wording in the last—not that it's going to matter. It says "approved corporation" where the prior ones talked about "licensee." I think it's a slip of drafting there. Perhaps with the committee's indulgence, we could just say—

Mr Wessenger: Yes, we could change that to "licensee."

The Chair: Sorry, could you just show again where that is?

Mr Jim Wilson: It's the last two lines, where it says, "approved corporation." It should say "the licensee." So strike "approved corporation."

The Chair: Okay, if that's clear. Thank you. We'll just do the final two amendments of this section, then we'll have a short pause so that we can all understand clearly what it is we're going to be voting on and then we will go forth. We have a Liberal amendment. 22.1.

1410

Mrs Fawcett: I move that section 31 of the bill be amended by adding the following section to the Nursing Homes Act after section 22:

"Restriction on reducing payments etc

"22.1 The minister may not reduce or withhold payments under section 20.11 or deduct an amount from a payment under section 22 if the reduction, withholding or deduction would put a resident's safety, health or security at risk or would cause any of the services or programs in a resident's plan of care to be interrupted."

The Chair: Thank you. Deferred. The final amendment under this section, Mr Wilson, is your amendment to sections 22.1 and 22.2.

Mr Jim Wilson: I move that section 31 of the bill be amended by adding the following sections to the Nursing Homes Act after section 22:

"Notice before deduction

"22.1(1) Before making a deduction under section 22, the minister shall serve on the licensee a notice setting out,

"(a) the minister's proposal to make a deduction under section 22:

"(b) the proposed amount of the deduction;

"(c) detailed reasons for making the deduction;

"(d) the requirements set out in subsection (4) for entitlement to a hearing by the appeal board;

"(e) the minister's power under subsection (5) to carry out the proposal; and

"(f) the requirements set out in subsection (6) for obtaining an extension of the time for giving a notice requiring a hearing.

"Service of notice

"(2) A notice under subsection (1) may be served personally or by registered mail addressed to the licensee at the licensee's most recent address known to the minister.

"Deemed time of service

"(3) If the notice is served by registered mail, the service shall be deemed to have been made on the seventh day after the day of mailing.

"Entitlement to a hearing

"(4) A licensee who is served with a notice under subsection (1) is entitled to a hearing by the appeal board if the licensee mails or delivers to the minister and to the appeal board, within thirty days after being served, a notice requiring a hearing by the appeal board.

"Minister may carry out proposal

"(5) If the licensee does not require a hearing in accordance with subsection (4), the minister may carry out the proposal described in the notice served under subsection (1).

"Extension of time

"(6) The licensee may apply to the appeal board for an extension of the time for giving a notice requiring a hearing, either before or after the time expires, and the appeal board,

"(a) may extend the time for giving the notice if it is satisfied that there are reasonable grounds for applying for the extension; and

"(b) may give such directions as it considers proper in light of the extension.

"Hearing

"(7) If the licensee requires a hearing in accordance with this section, the appeal board shall appoint a time and place for and shall hold a hearing.

"Same

"(8) The time appointed by the appeal board for a hearing must be within ninety days after the day the appeal board received the notice requiring the hearing.

"Parties

"(9) The parties to a proceeding before the appeal board under this section are,

"(a) the licensee;

"(b) the minister;

"(c) the person from whom the licensee accepted the payment; and

"(d) such other persons as the appeal board specifies.

"Proceedings

"(10) Subsections 20.4(3), (5) and (6) apply to the proceedings and decisions of the appeal board under this section

"Powers of appeal board

"(11) After a hearing by the appeal board under this section, the appeal board,

"(a) may, if the minister has not yet carried out the proposal described in the notice served under subsection (1),

"(i) allow the minister to carry out the proposal;

"(ii) direct the minister to refrain from carrying out the proposal; or

"(iii) find that an amount lower than that specified in the proposal is reasonable in the circumstances and allow the minister to deduct such lower amount under section 22:

"(b) may, if the minister has carried out the proposal under subsection (5),

"(i) find that the proposal was reasonable in the circumstances;

"(ii) direct the minister to pay the amount deducted to the licensee; or

"(iii) find that an amount lower than that specified in the proposal was reasonable in the circumstances and direct the minister to pay to the licensee the difference between the amount specified in the proposal and the amount that the appeal board found was reasonable;

"(c) may substitute its opinion for that of the minister; and

"(d) may make such other order as it considers just.

"Powers of court on appeal

"22.2 On an appeal to the Divisional Court from a decision of the appeal board under section 22.1, the Divisional Court.

"(a) may affirm or rescind the decision of the appeal board;

"(b) may substitute its opinion for that of the minister or the appeal board; and

"(c) may exercise all the powers of the appeal board."

Just to add comment to that, it's again a very important amendment that I've put forward primarily on behalf of the Ontario Nursing Home Association. They believe deeply that notices should be served before deductions and that it should be required on behalf of the minister to do that, and secondly, that there should be proper appeal mechanisms in this legislation. So far, in our clause-by-clause deliberations, the government has refused to accept these suggestions.

The Chair: We will take a short recess of up to five minutes, just to order the votes on the deferred items.

nutes, just to order the votes on the deferred items.

The committee recessed at 1416 and resumed at 1426.

The Chair: We are now ready to deal with the deferred votes. Just to assist everyone, because there is a considerable number, I will read the section and note the party that moved the motion, and also the number.

The first one, then, section 28, a Liberal amendment, 20.1(8.2): Shall the motion carry? Defeated.

Section 28, Liberal motion 20.1(9.2): Shall the motion carry? Defeated.

Section 28, government motion 20.1.1. All in favour? Opposed? Passed.

Government motion, again, section 28, 20.1.2: Shall the motion carry? Agreed.

Government motion 20.2: Shall it carry? Carried.

Section 28, Liberal motion 20.2.1: Shall the motion carry? Defeated.

Shall government motion 20.3 carry? Carried.

Liberal motion 20.3(1), (2.1), (3), (4), (5), (7): Shall the motion carry? Defeated.

Conservative motion, section 28, 20.3.1: Shall the motion carry? Defeated.

Section 28, Liberal motion 20.3: Shall the motion carry? Defeated

Section 28, Liberal motion 20.3.2 and 20.3.3: Shall the motion carry? Defeated.

Government motion 20.4(1) and (2): Shall the motion carry? Carried.

Government motion, again, section 28, 20.4(3): Shall the motion carry? Carried.

Government motion-

Mrs Sullivan: Recorded vote, please, on 20.4(3).

The Chair: Government motion 20.4(3) or—sorry, it's just that there are two—20.4(4)?

Mrs Sullivan: No, 20.4(3). The Chair: A recorded vote. Mr Jim Wilson: We just did (3).

Mrs Sullivan: Yes, a government motion.

Aves

Cooper, Hope, Jamison, O'Connor, Wessenger, Wilson (Simcoe West), Wiseman.

The Chair: The motion is carried.

Mr Jim Wilson: You'd better ask who doesn't like it.
The Chair: Oh, sorry. I'm getting ahead of myself.
Those opposed?

Nays

Fawcett, O'Neill (Ottawa-Rideau), Sullivan.

The Chair: The motion is carried.

Government motion 20.4(4): Shall the motion carry? Carried.

Liberal motion 20.4(3) and (6): Shall the motion carry? Defeated.

Section 28, government motion 20.4(5.1) to (5.4): Shall the motion carry? Carried.

Government motion 20.4(6): Shall the motion carry? Carried.

Government motion 20.4(7.1): Shall the motion carry? Carried.

Government motion 20.8: Shall the motion carry? Carried.

Liberal motion 20.8(d): Shall the motion carry? Defeated.

Liberal motion 20.8(2) and (3): Shall the motion carry? Defeated.

Liberal motion 20.8.1—

Mr Jim Wilson: A recorded vote.

The Chair: A recorded vote on the Liberal motion, 20.8.1.

All those in favour of the motion?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Nays

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

Section 28, government motion 20.9: Shall the motion carry? Carried.

Shall section 28, as amended, carry? Carried.

We then move on to section 29, Liberal motion 20.11(2): Shall the motion carry? Carried.

Government motion 20.11(3): Shall the motion carry? Carried.

Conservative motion 20.11.1 and 20.11.2—

Interjection: A recorded vote.

The Chair: A request for a recorded vote. Shall the motion carry?

All those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Navs

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

Conservative amendment 20.13(1)(a): Shall the motion—

Mr Jim Wilson: A recorded vote.

The Chair: All those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Nays

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated. 20.13(1)(c): Shall the motion carry?

Mrs Sullivan: A recorded vote.

Mr Wessenger: No.

The Chair: Same vote?

Mr Wessenger: Same vote.

The Chair: Same vote. The motion is defeated—and recorded.

The next is Conservative motion 20.13.1.

Mr.Jim Wilson: A recorded vote.

The Chair: A recorded vote. Same vote?

Mr Wessenger: Same vote.

The Chair: Same vote. The motion is defeated.

The next is a Liberal amendment 20.13.2.

Mrs Sullivan: A recorded vote.

The Chair: A recorded vote is requested. Same vote?

Mr Wessenger: Yes.
Mrs Sullivan: Reversed.

The Chair: Same vote. The motion is defeated. Mrs Sullivan had a good lunch.

Conservative motion 20.14(1)(a): Shall the motion carry?

Mr.Jim Wilson: I would like a recorded vote.

The Chair: Same vote? Okay, the motion is defeated. Government motion 20.14: Shall the motion carry?

Government motion 20.15: Shall the motion carry? Carried.

Government motion 20.15(2): Shall the motion carry?

Liberal motion 20.15: Shall the motion carry? Defeated.

Sorry, I'm going a little quickly there.

Conservative motion 20.15—

Mr.Jim Wilson: A recorded vote.

The Chair: A recorded vote. Shall the motion carry? All those in favour?

Ave

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Nays

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

Shall section 29, as amended, carry? Carried.

Government motion 21(1)(e), shall the motion carry? Carried.

Government motion 21(2)(b), shall the motion carry? Carried.

Shall section 30, as amended, carry? Carried.

Section 30.1, Liberal amendment 21.1, shall the motion carry? Carried.

Mrs Sullivan: Mr Chairman, did we leave out one motion from section 30, a government motion to section 21.1?

The Chair: Not moved.

Mrs Sullivan: All right. Thanks.

The Chair: We have passed 21.1, so I would now ask, shall section 30.1 carry? Carried.

Section 31, Conservative amendment 22, shall the motion—

Mr Jim Wilson: Could I have a recorded vote on this and the following three, Mr Chairman?

The Chair: Okay. A recorded vote is requested. The amendment, section 22, Mr Wilson, all those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: Those opposed?

Nays

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

Another Conservative amendment 22, same vote?

Interjections: Same vote.

The Chair: The third Conservative amendment to section 22, same vote?

Interjections: Same vote.

The Chair: Liberal amendment 22.1, shall the motion carry?

Interjections: No.

The Chair: Okay, defeated.

Conservative motion 22.1 and 22.2, recorded vote. All those in favour?

Ayes

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: Those opposed?

Navs

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman

The Chair: The motion is defeated.

Mr Jim Wilson: We also stood down the substitute decisions stuff.

The Chair: Yes, correct. I'll just find that. That is section 37.1 of the bill, and it was a government amendment to section 39.

Mrs Sullivan: Recorded vote.

The Chair: Shall the motion carry? Those in favour?

Ayes

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: Those opposed?

Nays

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: The motion is carried.

Shall section 37.1 carry? Carried.

I didn't put the vote on section 31. Shall section 31 carry? Carried.

We'll then move on to section 32, and I have a government motion 24(1). Mr Wessenger.

Mr Wessenger: I move that the definition of "record" in subsection 24(1) of the Nursing Homes Act, as set out in

section 32 of the bill, be amended by adding, after "form" in the last line, "but does not include that part of a record that deals with quality management activities or quality improvement activities."

The Chair: Shall the motion carry? Carried. Government motion 24(2)(b), Mr Wessenger.

Mr Wessenger: I move that clause 24(2)(b) of the Nursing Homes Act, as set out in section 32 of the bill, be struck out and the following substituted:

"(b) may, if he or she has reasonable grounds to believe that records or other things pertaining to a nursing home are kept in a place that is not in the home, enter the place at all reasonable times in order to inspect such records and other things."

The Chair: Shall the motion carry? Carried. Liberal amendment 24(2)(b), Ms Sullivan.

Mrs Sullivan: I won't be putting that amendment, Mr Chairman.

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The Chair: A second Liberal motion to the same—

Mrs Sullivan: I won't be moving that amendment.

The Chair: Not moved, and a further Liberal motion to 24(2.1).

Mrs Sullivan: I am not moving that amendment.

The Chair: That is not moved. A Conservative motion to 24(2) and (3).

Mr Jim Wilson: I move that subsections 24(2) and (3) of the Nursing Homes Act, as set out in section 32 of the bill, be struck out and the following substituted:

"Inspection

"(2) An inspector may at all reasonable times enter and inspect a nursing home, for the purpose of determining whether there is compliance with this act, the regulations, a licence or a service agreement."

The Chair: Shall the motion carry? All those in favour? Opposed? Defeated.

We then go to another Conservative motion, 24(4.1).

Mr Jim Wilson: I move that section 24 of the Nursing Homes Act, as set out in section 32 of the bill, be amended by adding the following subsection:

"Limitation on inspectors' powers

"(4.1) Subsection (4) does not give an inspector the authority to conduct an examination or test on an individual."

This is simply an attempt to clear up the terminology, particularly "examination," to ensure that inspectors are not in any way conducting medical examinations or tests.

Mrs Sullivan: Recorded vote, please.

The Chair: A recorded vote is requested. Shall the motion carry? All those in favour?

Ayes

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: Those opposed?

Navs

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: It is defeated.

Liberal amendment 24(4.1), (4.2) and (4.3).

Mrs Sullivan: I move that section 24 of the Nursing Homes Act, as set out in section 32 of the bill, be amended by adding the following subsections:

"Exception, solicitor-client privilege

"(4.1) Subsection (4) does not override any solicitorclient privilege to which a record is subject.

"Exception, law enforcement

"(4.2) An inspector is not entitled to have access to a record or part of a record whose disclosure could reasonably be expected to produce one of the results described in subsection 14(1) of the Freedom of Information and Protection of Privacy Act (law enforcement).

"Exception, personnel records, quality review, etc.

"(4.3) An inspector is not entitled to have access to a personnel record or to a record or part of a record dealing with.

"(a) quality review activities;

"(b) peer review or performance review activities; or

"(c) quality improvement activities."

The Chair: Shall the motion carry? Defeated. Conservative amendment 24(11).

Mr Jim Wilson: I move that subsection 24(11) of the Nursing Homes Act, as set out in section 32 of the bill, be amended by inserting after "at the inspector's request" in the fourth and fifth lines, "and at a time that is mutually agreed upon".

The Chair: Shall the Conservative motion carry? All those in favour? Opposed? Defeated.

Another Conservative amendment, 24(11.1).

Mr Jim Wilson: I move that section 24 of the Nursing Homes Act, as set out in section 32 of the bill, be amended by adding the following subsection after subsection (11):

"Reimbursement of expenses

"(11.1) The minister shall reimburse the licensee of a nursing home for all extraordinary expenses incurred in the preparation, production and interpretation of records of the home for an inspector."

The Chair: That is out of order under section 56 of the standing orders.

Government amendment 24(13).

Mr Wessenger: I move that section 24 of the Nursing Homes Act, as set out in section 32 of the bill, be amended by adding the following subsection:

"Inspection report

"(13) Upon completing an inspection under this section, an inspector shall prepare an inspection report and shall give a copy of the report to the licensee of the nursing home."

The Chair: Shall the government motion carry? Carried.

Conservative motion 24(13).

Mr Jim Wilson: This is a much better motion, dealing with the same subject.

I move that section 24 of the Nursing Homes Act, as set out in section 32 of the bill, be amended by adding the following subsection:

"Inspection report

"(13) Within thirty days of completing an inspection under this section, an inspector shall submit a full report of all findings, conclusions and recommendations to the administrator of the nursing home."

The Chair: Shall Mr Wilson's motion carry? All in favour? Opposed? Defeated.

Government motion 24.0.1. Mr Wessenger.

Mr Wessenger: I move that section 32 of the bill be amended by adding the following section to the Nursing Homes Act after section 24:

"Warrant

"24.0.1(1) A justice of the peace may issue a warrant authorizing an inspector named in the warrant to enter premises specified in the warrant and to exercise any of the powers mentioned in subsection 24(4), if the justice of the peace is satisfied on information under oath that,

²(a) the inspector has been prevented from exercising a right of entry to the premises under subsection 24(2) or has been prevented from exercising a power under subsection

24(4); or

"(b) there are reasonable grounds to believe that the inspector will be prevented from exercising a right of entry to the premises under subsection 24(2) or will be prevented from exercising a power under subsection 24(4).

"Expiry of warrant

"(2) A warrant issued under this section shall name a date on which it expires, which date shall not be later than thirty days after the warrant is issued.

"Extension of time

"(3) A justice of the peace may extend the date on which a warrant issued under this section expires for an additional period of no more than thirty days, upon application without notice by the inspector named in the warrant.

"Use of force

"(4) An inspector named in a warrant issued under this section may use whatever force is necessary to execute the warrant and may call upon a police officer for assistance in executing the warrant.

"Time of execution

"(5) A warrant issued under this section may be executed only between 8 am and 8 pm, unless the warrant specifies otherwise.

"Other matters

"(6) Subsections 23(2) and 24(5) to (13) apply with necessary modifications to an inspector executing a warrant issued under this section."

Mrs O'Neill: Is there enough detail in this particular amendment or does the government foresee detailed regulations going together with this?

Mr Wessenger: We don't make regulations about warrants.

Mrs O'Neill: Why I'm asking that question is—you may not make regulations about warrants, and I understand that, but how the warrant, when, all of these things are part of this. I am still very concerned that a good

precedent be established and that there be good reasons for this very, very threatening, jackboot kind of operation.

I'm still having difficulty with it and I think the nursing homes are going to have difficulty with it as are the other two kinds of facilities we've dealt with.

Mr Wessenger: I might just indicate that this was prepared at the request of the Ontario Medical Association. They wanted to have a warrant as evidence if someone comes into their office, so this was done.

Mrs O'Neill: This is much broader than doctors' offices, folks. I'm sorry.

Mrs Sullivan: That's right. It's quite different from what the Ontario Medical Association requested. The OMA certainly did not request the inclusion of the use of "whatever force is necessary" powers given to the inspector. The OMA has been quite satisfied with what's included in our amendment, which says that the inspector may call on a police officer for assistance in execution.

The Chair: Shall the government motion carry?

Mrs O'Neill: Recorded vote, please.

The Chair: Recorded vote?

Mrs O'Neill: Yes.

The Chair: All those in favour?

Aves

Cooper, Hope, Jamison, O'Connor, Wessenger, Wilson (Simcoe West), Wiseman.

The Chair: Those opposed?

Navs

Fawcett, O'Neill (Ottawa-Rideau), Sullivan.

The Chair: Liberal amendment 24.1.

Mrs Sullivan: As a result of the passage of the last motion, I will not place this motion but I do want—

The Chair: It's 24.1.

Mrs Sullivan: It would be 24.0.1 renumbered. I do want to underline how strongly we object to the government's wording in its motion and how strongly we feel that appropriate wording is that of our motion, which says that the inspector may call on a police officer for assistance and doesn't provide the inspector with additional powers to pull a gun or whatever else is seen to be additional use of force.

The Chair: So that motion is not moved.

Mr Jim Wilson: May I express my disappointment that Mrs Sullivan didn't put forward the Liberal motion she feels so strongly about. I was looking forward to a recorded vote in which I could vote against it.

Also, being as polite as possible, I don't think the public should be scared by the wording of the government's motion. It's quite a normal wording. It only makes sense that if inspectors are to carry out the object of the warrant, they need to use force. Perhaps it is the wording, when it says "use of force" and "may use whatever force is necessary," that scares people. Let's just reassure the public that there's nothing terribly unusual about this provision.

The Chair: I think the points have been made.

Mrs O'Neill: I doubt somehow that it will be implemented.

Mr Jim Wilson: Inspectors don't have guns, Mr Chairman.

Mrs Sullivan: I just wanted to point out one more thing and then I will not refer to this again.

The Chair: One last comment.

Mrs Sullivan: The very last bill that used a warrant as part of the drafting of the legislation included the wording of my amendment and not that of the government amendment. In fact the government amendment wording is the unusual wording. That's the last word on the issue.

Mr.Jim Wilson: How is that bill now?

The Chair: We now move to a government amendment, section 24.2.

Mr Wessenger: I move that section 32 of the bill be amended by adding the following section to the Nursing Homes Act after section 24.1:

"Protection from reprisals

"24.2(1) No person shall do anything or refrain from doing anything in retaliation for another person making a disclosure to an inspector so long as the disclosure was made in good faith.

"No interference

"(2) No person shall seek by any means to compel another person to refrain from making a disclosure to an inspector."

The Chair: Shall the government motion carry? Carried.

Shall section 32, as amended, carry? Carried.

Shall section 33, as in the bill, carry? Carried.

We now move to section 34, a government amendment, sections 29 to 33.

Mr Wessenger: I move that section 34 of the bill be struck out and the following substituted:

"34. Sections 29 to 33 of the act are repealed and the following substituted:

"Residents' council

"29(1) If a request for the establishment of a residents' council is made to the administrator of a nursing home by at least three persons, each of whom is a person mentioned in subsection (2),

"(a) the administrator shall promptly notify the director and the licensee of the nursing home of the request; and

"(b) the licensee shall assist the persons who made the request in establishing a residents' council for the nursing home within sixty days of the request.

"Request for residents' council

- "(2) For the purpose of subsection (1), the following persons may request the establishment of a residents' council for a nursing home:
 - "1. A resident of the nursing home.
- "2. A person who is lawfully authorized to make a decision on behalf of a resident of the nursing home concerning the resident's personal care.

"Right to be a member

"(3) Subject to subsection (4), the following persons are entitled to be members of the residents' council of a nursing home:

"1. A resident of the nursing home.

"2. A person who is lawfully authorized to make a decision on behalf of a resident of the nursing home concerning the resident's personal care.

"3. A person selected by the resident or by the person who is lawfully authorized to make a decision on behalf of the resident concerning the resident's personal care.

"Who may not be a member

"(4) The following persons may not be members of the residents' council of a nursing home:

"1. The licensee of the nursing home.

"2. An officer or director of the licensee.

"3. A person with a controlling interest in the licensee.

"4. The administrator of the nursing home.

"5. Any other member of the staff of the nursing home.

"Appointment by minister

"(5) At the request of a residents' council, the minister may appoint no more than three persons to be members of the residents' council, and those persons shall serve as members at the pleasure of the residents' council.

"Same

"(6) Only a person who lives in the area in which the nursing home is located and who is not employed by and does not have a contractual relationship with the ministry may be appointed under subsection (5).

"Meeting

"29.1(1) Unless a nursing home has a residents' council, the licensee of the nursing home shall, at least once in each year, convene a meeting of the residents of the nursing home and the persons who are lawfully authorized to make a decision on behalf of a resident concerning the resident's personal care, to advise them of their right to establish a residents' council.

"Results of meeting

"(2) Within thirty days after the meeting, the licensee shall notify the director of the results of the meeting.

"Powers of residents' council

"30. It is the function of a residents' council of a nursing home, and the council has the power, to,

"(a) advise residents of the nursing home respecting their rights and obligations under the act;

"(b) advise residents of the nursing home respecting the rights and obligations of the licensee of the nursing home under this act and under the service agreement relating to the nursing home;

"(c) meet regularly with the licensee or, if the licensee is a corporation, with representatives of the licensee, to,

"(i) review inspection reports relating to the nursing home received by the licensee under subsection 24(13),

"(ii) review the allocation of money for accommodation, care, services, programs and goods provided in the nursing home,

"(iii) review the financial statements relating to the nursing home filed with the minister under the regulations, and

"(iv) review the operation of the nursing home;

"(d) attempt to mediate and resolve a dispute between the licensee and a resident of the nursing home; and

"(e) report to the minister any concerns and recommendations that in its opinion ought to be brought to the minister's attention.

"Residents' council assistant

"31(1) With the consent of a residents' council, the minister may appoint a residents' council assistant to assist the residents' council in carrying out its responsibilities.

"Duties

"(2) In carrying out his or her duties, a residents' council assistant shall take instructions from and report to the residents' council.

"Information and assistance

"32(1) A licensee of a nursing home shall cooperate with the residents' council and the residents' council assistant and shall provide them with such financial and other information and such assistance as is required by the regulations.

"Obstruction

"(2) No person shall refuse entry to a nursing home to a residents' council assistant or otherwise hinder, obstruct or interfere with a residents' council assistant carrying out his or her duties.

"Immunity

"33. No proceeding shall be commenced against a member of a residents' council or a residents' council assistant for any act done under section 30, unless the act is done maliciously or without reasonable grounds."

The Chair: Thank you.

Mr Jim Wilson: I would like to comment on this because I know much of this is currently in the act when it comes to residents' councils, and I am supportive of residents' councils. But I just wonder—and I appreciate the parliamentary assistant's comments—with respect to the fact that now that the Advocacy Act is in, and advocates will be in these nursing homes whenever the act comes into effect and is up and running, I'm worried that the voices of residents themselves will be drowned out by advocates, the power of the minister to appoint people to these residents' councils.

It seems there will be a lot more professionals around giving their advice on what's good for the residents than the residents themselves. I'm just wondering, since much of it is supposed to be in practice now, but we've not had the experience of advocates in the homes, as under the Advocacy Act, has the government really thought this through?

Secondly, I want to raise the question of costs. As I understand it, the onus is placed on the home for the cost of these councils. Now councils in and of themselves don't cost that much, but I suppose you now have a residents' council assistant. Was there discussion with homes in this respect in terms of what costs might be incurred?

I think there's a lot of worry out there that services are being cut, and we don't want to download any more costs on to the backs of nursing homes or homes for the aged or charitable homes if we can avoid it. Basically I appreciate his comments because I know the amendment will go

forward, but I just wonder if the government has thought it through in light of the new experience out there.

Mr Wessenger: First of all, with respect to the appointment of a residents' council assistant, it is with the residents' council; it's not something that's done unilaterally. With respect to the additional persons being appointed, again it's at the request of the residents' council. So these are only done at the residents' council's request.

Mr Jim Wilson: It also says in that section that they serve "at the pleasure." That means that at any time the residents' council could vote to dismiss them?

Mr Wessenger: Yes.

Mr Jim Wilson: Okay, I just wanted to be clear on that.

The Chair: Thank you. Shall the motion carry? Carried. Shall section 34, as amended, carry? Carried.

Shall section 35, as in the bill, carry? Carried.

Then we move to section 36 and two government amendments.

Mr Wessenger: I move that section 36 of the Nursing Homes Act, as set out in section 36 of the bill, be amended by striking out "20.1(7), (8) and (10), section 20.3 and subsections 20.4(8) and 20.6(5)" in the fourth and fifth lines and substituting "20.1(7), (8), (8.1), (8.2), (8.3), (8.3.1), (8.4), (8.7) and (10), section 20.1.1 and subsections 20.3(1), 20.4(2.3) and (8) and 20.6(5)."

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The Chair: Shall the government motion carry? Carried.

There is just the one amendment to 36, am I right?

Mr Wessenger: Yes.

The Chair: Shall section 36 then, as amended, carry? Carried.

Shall section 37, as in the-

Mr Wessenger: No, we have amendments to 37.

The Chair: We move then to subsection 37(1), a government amendment.

Mr Wessenger: I move that paragraph 1 of section 38 of the Nursing Homes Act, as set out in subsection 37(1) of the bill, be amended by striking out "and 'short-stay accommodation" in the third and fourth lines and substituting ", 'short-stay program' and 'veteran."

It's a definition section.

The Chair: Shall the government motion carry? Carried.

Mr Jim Wilson: I will not be moving PC motion 37(1).

The Chair: Yes, 37(1). You're not—

Mr Jim Wilson: We're not moving it; it's not necessary.

The Chair: Not moved. Shall subsection 37(1), as amended, carry?

Mr Wessenger: The counsel seems to think there is another.

The Chair: There was another 36.

Mr Wessenger: That was the one we replaced. It's all right.

The Chair: We'll get our cylinders going again here. Did we just pass 37(1), as amended?

Mr Wessenger: Yes, as amended.

The Chair: Okay. Shall subsections 37(2) and (3), as in the bill, carry? Carried.

Then section 37(4), government amendment.

Mr Wessenger: I move that paragraph 5 of section 38 of the Nursing Homes Act, as set out in subsection 37(4) of the bill, be struck out and the following substituted:

"5. requiring that parts of the licensed bed capacity of nursing homes be set aside for various classes of accommodation, and regulating the amount of bed capacity that must be set aside for each class:"

Mr Jim Wilson: Mr Chairman, could I make a point on that since I think it's the last opportunity to do so? I just want assurance from the parliamentary assistant that staff will provide us with the comprehensive briefing I requested the other day concerning the different rates, types of accommodation etc.

Mr Wessenger: I'm sure that your request has been noted.

The Chair: Thank you. Shall the government motion carry? Carried.

Shall subsection 37(4), as amended, carry? Carried. Shall subsection 37(5), as in the bill, carry? Carried. We move then to 37(6) and a Conservative amendment.

Mr Jim Wilson: It's really no longer relevant since the previous amendment didn't pass.

The Chair: Not moved. Shall subsection 37(6), as in the bill, carry? Carried.

Shall subsection 37(7), as in the bill, carry? Carried. Subsection 37(8): I have a government amendment.

Mr Wessenger: I move that paragraph 19 of section 38 of the Nursing Homes Act, as set out in subsection 37(8) of the bill, be struck out and the following substituted:

"19. prescribing the maximum amounts or governing the manner of determining the maximum amounts that may be demanded or accepted from or on behalf of a resident under clauses 21(1)(a) and (b), prescribing the information or proof that is to be provided before a determination is made, requiring that the information provided for the purpose of a determination be provided under oath, and prescribing the persons or other entities who may make the determination;"

The Chair: Shall the government motion carry? Carried.

Shall subsection 37(8), as amended, carry? Carried. Shall subsection 37(9), as in the bill, carry? Carried. Shall subsection 37(10), as in the bill, carry? Carried.

We then come to subsection 37(11), and the first amendment is a Conservative amendment. Mr Wilson.

Mr Jim Wilson: Just one moment, Mr Chairman. There is a government motion—

The Chair: There is a government motion—Mr Jim Wilson: —for a later paragraph.

The Chair: —for a later paragraph.

Mr Jim Wilson: I move that paragraph 29 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"29. governing applications to placement coordinators for a determination, including prescribing the placement coordinators to whom applications may be made and the frequency with which applications may be made;"

The Chair: Shall Mr Wilson's motion carry? All those in favour? Defeated.

I then have a government motion. Mr Wessenger.

Mr Wessenger: I move that paragraph 31 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill. be struck out.

This deletes the regulation-making power requiring and governing consent to admission and care provided in a home, because consent to admission is now required under subsection 20.1(8.4).

The Chair: Shall the motion carry? Carried. What was the number on that again, please?

Mr Wessenger: Subsection 37(11), paragraph 31 of section 38.

The Chair: Fine. Thank you. That carries.

I then have a Liberal amendment, 31.1. Ms Sullivan. Mr Wessenger believes he has one which covers yours, Ms Sullivan.

Mrs Sullivan: But his doesn't come till later. I just want to be certain that he puts it on the table, so I'll read mine in.

I move that subsection 37(11) of the bill be amended by adding the following paragraph to section 38 of the Nursing Homes Act:

"31.1. prescribing the qualifications for persons and entities to be designated as placement coordinators;"

I'll stand that down until the government reads in its motion.

The Chair: Deferred, I then have a second Liberal amendment. Ms Sullivan.

Mrs Sullivan: I will read it in and then stand it down.

I move that paragraph 32 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out.

I will stand that down.

The Chair: We'll stand that down. We then come to the government amendment. Mr Wessenger.

Mr Wessenger: I move that paragraph 32 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"32. prescribing, for the purpose of clause 20.1(8.5)(c), additional circumstances which are grounds for a licensee to withhold approval for the admission of a person to a nursing home;

"32.1. prescribing and governing the obligations of a licensee in relation to giving or withholding approval for the admission of a person to a nursing home, and governing the written notice required to be given under subsection 20.1(8.6)."

The Chair: Shall the government motion carry? Carried.

Mrs Sullivan: Mr Chairman, I will therefore withdraw the amendment proposed to paragraph 32 of section 38.

The Chair: Yes. So 32 is withdrawn. Your other one remains until we get to it, right?

Mrs Sullivan: Yes.

The Chair: The next amendment is also a government amendment. Mr Wessenger.

Mr Wessenger: I move that subsection 37(11) of the bill be amended by adding the following paragraph to section 38 of the Nursing Homes Act, after paragraph 32.1:

"32.2. requiring that placement coordinators have certain qualifications or meet certain requirements and prescribing such qualifications or requirements."

The Chair: Shall the government motion carry? Carried.

1510

Mrs Sullivan: Mr Chairman, as a result of that motion, I will withdraw my motion to section 38 of 37(11).

The Chair: That was 31.1?

Mrs Sullivan: Yes.

The Chair: Okay, that is withdrawn. We then have a government motion.

Mr Wessenger: I move that paragraph 34 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be amended by:

(i) adding, after "other" in the last line of subclause (i), "documents and"; and

(ii) striking out "and" at the end of subclause (i) and adding the following subclause after subclause (i):

"(i.1) requiring that the information provided by the licensee for the purpose of the reconciliation be provided under oath, and"

Mrs Sullivan: Recorded vote.

The Chair: A recorded vote is requested. Shall the government motion carry? All those in favour?

Aves

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: All those opposed?

Navs

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: The motion is carried.

I then have a Conservative amendment.

Mr Jim Wilson: I move that subparagraph (i) of paragraph 34 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"(i) requiring the licensee to provide, at specified intervals, proof of maintenance and operating costs, information about the financial affairs and the level of occupancy of the nursing home and other information, and"

This is the last opportunity for the government to get it right, as the previous minister was fond of saying, and to delete the reference to audited financial statements, which I am told you don't need. What you need is audited financial information, and if you're a chartered accountant and you see the word "statement," you start racking up the bill. A little common sense would be appreciated in this area, and I would like a recorded yote on the amendment.

The Chair: A call for a recorded vote. Shall Mr Wilson's motion carry? All those in favour?

Aves

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Navs

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

We have a second amendment. Mr Wilson.

Mr Jim Wilson: I move that paragraph 36 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"36. governing service agreements, including their replacement and cancellation and including prescribing provisions that must be contained in all service agreements and matters that must be provided for in all service agreements."

Mr Chairman, I would like a recorded vote.

The Chair: Shall Mr Wilson's motion carry? All those in favour?

Ayes

Fawcett, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

The Chair: All those opposed?

Nays

Cooper, Hope, Jamison, O'Connor, Wessenger, Wiseman.

The Chair: The motion is defeated.

Next is a government motion.

Mr Wessenger: I move that paragraph 39 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"39. governing short-stay programs in nursing homes."

The Chair: Shall the government motion carry? Carried.

A government motion again. Mr Wessenger.

Mr Wessenger: I move that paragraph 42 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"42. governing the quality management system to be developed and implemented by licensees for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to residents of nursing homes."

The Chair: Shall the government motion carry? Carried.

A Conservative motion.

Mr Jim Wilson: I move that paragraph 42 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be struck out and the following substituted:

"42. governing quality management programs, including their development, implementation and revision:"

I think this is better than what the government just passed, Mr Chairman, and I'd ask for a recorded vote.

The Chair: A call for a recorded vote.

Shall Mr Wilson's motion carry? All those in favour?

Aves

Wilson (Simcoe West).

The Chair: All those opposed?

Navs

Cooper, Fawcett, Hope, Jamison, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessenger, Wiseman.

The Chair: The motion is defeated. Same old gang. The government motion, Mr Wessenger.

Mr Wessenger: I move that paragraph 43 of section 38 of the Nursing Homes Act, as set out in subsection 37(11) of the bill, be amended by striking out "of which notice must be given" in the third and fourth lines and substituting "which must be set out in the notice."

The Chair: Shall the government motion carry? Carried.

Mr Wessenger: I move that subsection 37(11) of the bill be amended by adding the following paragraph to section 38 of the Nursing Homes Act, after paragraph 43:

"44. governing inspection reports."

The Chair: Shall the government motion carry? Carried.

Now, shall subsection 37(11), as amended, carry? Carried.

Mr Jim Wilson: I was just going to indicate that there is one more PC motion, perhaps. I won't be introducing it.

The Chair: Okay. thank you.

Interjections.

Mr Jim Wilson: No, it's dealt with; it's veterans.

The Chair: Shall subsection 37(12) carry as in the bill? Carried.

Shall section 37, as amended, carry? Carried.

We then move to part VIII, "Commencement and Short Title." Shall section 38 carry? Carried.

Shall section 39 carry? Carried.

Shall the title of the bill carry? Carried.

Shall I report the bill, as amended, to the House? Agreed.

We have removed that amendment. Mr Hope.

Mr Hope: Mr Chair, as we wind down the amendments to this, I just want to make a few comments. In the four weeks that we've heard public hearings and the three days of clause-by-clause, I've seen a lot of cooperation from all parties, and that's even including our House leader's office, which granted an extension. I am hoping that the cooperation we've seen in the four weeks and three days continue on into third reading of this piece of

legislation so that those who are waiting, recipients of this, can be expedited this year, within a very short time.

I just want to say thanks to you, as the Chair of the committee, and also to the two opposition parties for the cooperation that has been given on this bill.

The Chair: Thank you. I would like, if I might, as Chair, just to thank a number of—Mr O'Connor.

Mr Larry O'Connor (Durham-York): I just feel compelled, at this time, to acknowledge a few folks from the ministry. Within the bureaucracy, there has been an awful lot of work going into this. There has been the consultation that has taken place over a lot of years, and right from first reading in the House and through the committee process, we've had a lot of hard work taking place. Some of the people have been with us in the committee hearings, some of them haven't, and I want to acknowledge the hard work they've done. As you can tell by the number of amendments, the committee hearing process certainly did point to some need for changes and we've been able to accomplish that. I want to thank the opposition members for working with us through this process. I just wanted to point that out.

Mr Jim Wilson: I don't want to rain on anyone's parade. I want you to know that the cooperation came because we had a gun to our heads and that it wasn't the most free-will cooperation I've ever extended in my life. But I do want to say to you, Mr Chairman, that I think you did an excellent job and I appreciate your tolerance and patience. You guided us through this with extreme skill, and for that I'm grateful.

The Chair: Thank you. Ms Sullivan.

Mrs Sullivan: Mr Chairman, I too want to commend you. As usual, your work has been superlative. I'd also like to express the thanks of all members of the committee to Hansard, to legislative research, to legislative counsel and to the clerk for assisting us as we have gone through this process.

Additionally, I would like to indicate, on behalf of our party, that we hope this legislation will be scheduled very early in the session, because the passage and proclamation of this bill will affect the funding received in the long-term care sector and will have a significant and profound effect on the kinds of services and care that people receive in the community.

Mr Wessenger: I'd like to also add my thanks to members of the committee for the cooperative approach that has been taken with respect to this bill and how it's proceeded. I too look forward to having it proceed very quickly. I also appreciate very much the guidance the Chairman has given with respect to expediting the process of this bill and keeping us on track and not dealing with extraneous items.

I'd like, though, to particularly thank two members of ministry staff who've been invaluable and dedicated many hours to this legislation: Gail Czukar, our legislative—not our counsel here; for the ministry—who has been invaluable, and also Geoff Quirt, who has added a great deal of enlightenment to members with respect not only to this legislation, but to the whole question of long-term care

policy. I very much appreciate the efforts of those two ministry staff and, of course, all ministry staff. There are the ministry staff sitting back there, Louise Hurst, who's here today, and also political staff who've been very involved.

I think it's been a very worthwhile and thorough process. We can all be proud that we've got a good piece of legislation to go to the House.

The Chair: Just before breaking, perhaps I might express my appreciation, on behalf of all members of the committee in particular, to all of the groups and individuals who, over the course of our hearings, came before the committee, both those who presented in person and the many individuals and groups who wrote to the committee. I think we want to be sure to say thank you for so many people who participated in that way.

I want, as Chair, to also thank the parliamentary assistant for his cooperation, the two critics, all of the members. We've thanked a number of people who have helped us through these proceedings and I'd like to add the interpreters—merci beaucoup—and the broadcasting and recording service. I think whenever we are on the road, we owe a particular debt of gratitude to what they go through. I know it's been noted, but I'll note it as well: as usual, the excellent service from Hansard, from legislative research, the legislative counsel's office; again, ministry staff who have been very helpful. Last, but certainly not least, the ever-pleasant clerk, who has been able to get us through all kinds of problems. We really appreciate all of your efforts.

With that, we will draw these hearings to a close and we will reconvene at the call of the Chair.

The committee adjourned at 1523.





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Thursday 25 March 1993

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

*Chair / Président: Beer, Charles (York North/-Nord L)

Présidente suppléante: Vice-Chair / Vice-Président: Daigeler, Hans (Nepean L)

Drainville, Dennis (Victoria-Haliburton ND)

*Fawcett, Joan M. (Northumberland L)

Martin, Tony (Sault Ste Marie ND)

Mathyssen, Irene (Middlesex ND)

*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

White, Drummond (Durham Centre ND)

Wilson, Gary (Kingston and The Islands/Kingston et Les Îles ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

Witmer, Elizabeth (Waterloo North/-Nord PC)

Substitutions present / Membres remplacants présents:

Akande, Zanana L. (St Andrew-St Patrick ND) for Mr Martin and Mr Owens Cooper, Mike (Kitchener-Wilmot ND) for Mr Owens

Hope, Randy R. (Chatham-Kent ND) for Mr Martin

nope, Randy R. (Chatham-Kent ND) for Mr Martin

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Witmer

Jamison, Norm (Norfolk ND) for Mr Drainville

MacKinnon, Ellen (Lambton ND) for Mr Gary Wilson

O'Connor, Larry (Durham-York ND) for Mr Gary Wilson

Sullivan, Barbara (Halton Centre L) for Mr Daigeler

Wessenger, Paul (Simcoe Centre ND) for Mrs Mathyssen

Wiseman, Jim (Durham West/-Ouest ND) for Mr White

Also taking part / Autres participants et participantes:

Czukar, Gail, legal counsel, Ministry of Health

Wessenger, Paul, parliamentary assistant to the Minister of Health

Clerk / Greffier: Arnott, Douglas

Clerk pro tem / Greffière par intérim: Freedman, Lisa

Staff / Personnel:

Gottheil, Joanne, legislative counsel Spakowski, Mark, legislative counsel

^{*}In attendance / présents



